Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
202-479-8000

Group Number:
PG55

Group Name:
MONTGOMERY COUNTY GOVERNMENT

CareFirst BlueCross BlueShield

Out-of-Service Area Plan

A

Health Benefits Program

Prepared For

The Active and Retirees In

The Montgomery County

High Option and Standard Option

Point-of-Service Plan

Residing Outside

The Network Service Area

Table of Contents

Page Number

For Your Reference

- Customer Service Representatives are available to answer benefit and claim inquiries Monday through Friday from 8:00 a.m. until 8:00 p.m., Eastern Time (ET). Please contact Customer Service at 1-888-417-8385.

- You can also send written inquiries to Customer Service at:

  CareFirst BlueCross BlueShield
  National Accounts Dedicated Services
  P.O. Box 1739
  Cumberland, MD 21501

- To authorize inpatient medical services, please contact Utilization Management at the telephone number indicated on your identification card.

- To authorize inpatient mental health/substance abuse services, please call the telephone number indicated on your identification card.

Introduction

Montgomery County is pleased to offer you and your family access to excellent health care coverage. The Out-of-Service Area Plan ("Plan") administered by CareFirst BlueCross BlueShield (CareFirst), enables eligible employees, retirees and their families to receive affordable health care through a network style plan.

Overview

This Summary of Benefits (SB) describes the benefits offered under the Plan. Keep this SB in a handy location, so that you can refer to it when necessary. Refer to it when you need to find out information quickly or if you just want to know what your coverage includes.

If you have a question that is not covered in this SB, call Customer Service toll-free at 1-888-417-8385.

This Booklet Is a Summary of Benefits (SB)

This SB is meant to be informative and easy to understand. It was written to help you learn how your benefits work and how to use them most effectively. Please take some time to read through the SB. When faced with a benefit question, you will know where to turn in the SB for your answer.

The information provided in this SB summarizes your benefit plan. Montgomery County reserves the right to change, amend or terminate the plan at any time. This SB is not a contract and participation in this plan does not guarantee employment.

Understanding Key Terms

Certain key terms that relate to your benefits are used throughout this handbook. Those terms are defined in the Definitions Section of this SB.

Highlights of the Out-of-Service Area Plan

- The Plan covers most of your healthcare needs and enables you to choose where to receive services:
  - from an In-Network, Preferred Provider;
  - from a Participating Provider who contracts with CareFirst to provide services at a fixed cost (Participating Providers are not always in-network providers);
  - from any other covered provider that CareFirst recognizes as an eligible provider of medical services (Non-Participating Provider).
- When you go to a Participating Provider, who is out-of-network, you are covered at a percentage of the Allowed Benefit after you have met your annual deductible. Participating Providers have agreed to accept CareFirst's Allowed Benefit as payment in full for covered services. You will also have no claims to file and you will not be billed for any amount over the allowed amount. You or your participating provider must obtain any required authorization.

- Non-Participating providers are doctors and hospitals who do not participate with CareFirst. For these providers, you need to coordinate your own care and obtain any required authorization. You may need to pay for services up-front and then file claim forms for reimbursement. Non-Participating Providers may not accept CareFirst's Allowed Benefit as payment in full for covered services. You may be responsible for paying any charges that exceed the Allowed Benefit.

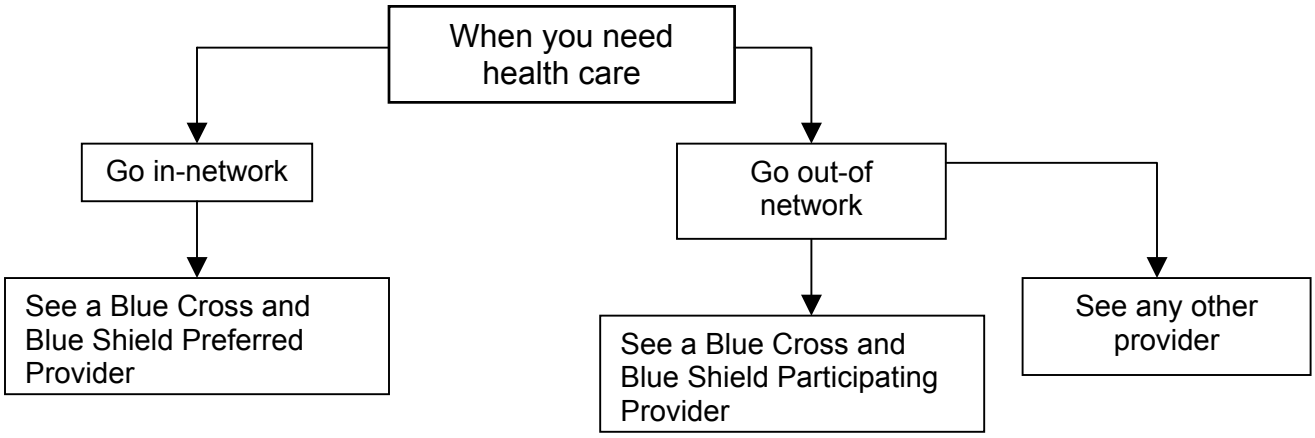
- Covered services include the following if medically necessary:

  - doctor's office visits
  - laboratory tests and X-rays
  - preventive care
  - inpatient and outpatient hospital services
  - mental health and substance abuse services

How the Out-of-Service Area Plan Works

In-Network vs. Out-of-Network Coverage

With this Plan, you can decide how to receive care every time you need health care services — In-Network or Out-of-Network.



In-Network coverage

When you need In-Network care, you see one of the Plan's Preferred Providers. A Preferred Provider is a licensed doctor/practitioner or facility/hospital invited to join CareFirst BlueCross BlueShield's network after a careful screening of credentials. Preferred Providers agree to deliver services covered by the Plan to Members at a fixed cost. By using an In-Network provider, you will receive a higher level of benefits, your out-of-pocket expense is less, and you will not have to fill out any claim forms. Your provider will obtain any authorization you may need.

Out-of-Network coverage

When you choose Out-of-Network coverage, you can see any covered provider, but you will receive a lower level of benefits. If you go to an Out-of-Network provider, there are two types of providers you can use — a CareFirst BlueCross BlueShield Participating Provider and a Non-Participating Provider. If you see a Participating Provider, the Plan will pay the provider directly, and there are no claim forms for you to fill out. You will need to obtain any authorization required. If there is any difference between what the Participating Provider actually charges for a service and what the Plan allows, you will not be responsible for paying that difference. You will be responsible for any Coinsurance and Deductible that may apply.

If you see a Non-Participating Provider, you may have to pay for your services up-front and submit a claim form. In addition, you will be responsible for the difference (if any), between the actual charge for a service and what the Plan allows. You will need to obtain any authorization required. (For more information on how to submit a claim, see page 10)

The Choice Is Yours

The following table shows the steps involved when you choose to go In-Network (see a Preferred Provider) or Out-of-Network (see a CareFirst BlueCross BlueShield Participating Provider or a Non-Participating Provider) for medical care.

In-Network	**If you see a Preferred Provider** ▪ You pay a small Copayment or Coinsurance ▪ You file no claims	**If you need hospitalization, home health care or hospice services, or outpatient speech, occupational or physical therapy.** ▪ Your doctor will obtain necessary approval and arrange services ▪ You file no claims

Out-of-Network	**If you see a Participating Provider** ▪ After you meet your Annual Deductible, the Plan pays Out-of-Network benefits directly to the doctor ▪ You pay a Coinsurance (usually after your Annual Deductible has been met) ▪ You file no claims	**If you see a Non-Participating Provider** ▪ You may need to pay the full amount of services at the time the services are rendered ▪ You will file a claim and, after you have met your Annual Deductible, receive reimbursement of Allowed Benefit for services
	If you need hospitalization, home health care or hospice services, or outpatient speech, occupational or physical therapy:	
	If you see a Participating Provider ▪ You call the Utilization Management section of CareFirst BlueCross BlueShield for approval of services ▪ You pay a Coinsurance (usually after your Annual Deductible has been met)	**If you see a Non-Participating Provider** ▪ You call the Utilization Management section of CareFirst BlueCross BlueShield for approval of services ▪ You pay your bills at the time of service, or authorize your provider to file a claim

	▪ You file no claim forms	▪ You may be responsible for paying any expenses not covered by the Plan ▪ You file claim forms

Out-of-Pocket Costs

Your out-of-pocket costs will depend on the type of provider you or your family members see when you need care:

- Preferred Provider (*In-Network*)
- Participating Provider (*Out-of-Network*)
- Any other covered provider (*Out-of-Network*)

Annual Deductible*

For all Out-of-Network services, you must first meet an Annual Deductible before the Plan will begin to provide benefits. Your Deductible will depend on the level of coverage you have selected and whether services are rendered In- or Out-of-Network. The following Deductibles will apply:

	In-Network	Out-of-Network
Individual coverage	$0	$250
Family coverage	$0	$500

If you have family coverage, the family deductible can be met by any number of family members. However, one family member may not contribute more than the individual deductible toward the family limit.
Once the family deductible is met, the deductible for all covered family members will be satisfied.

After you meet the Deductible, you will also be responsible for Coinsurance.

Copayment

A Copayment is the amount you pay to the Preferred Provider at the time services are received. For certain covered services, you will be asked to make a Copayment. For a more complete list of services subject to the Copayment, please refer to the Schedule of Benefits for High Option or Standard Option benefits or call Customer Service at 1-888-417-8385.

Coinsurance

For all Out-of-Network and some In-Network services, you are responsible for a percentage of the cost of services you receive, called Coinsurance.

In addition to the Copayment, Preferred Providers have agreed to accept a fixed amount for each service offered by the Plan, called the Allowed Benefit. For most In-Network services, including Preventive Care Services, the Plan pays 100% of the Allowed Benefit.

If you go Out-of-Network to a Participating Provider, the Plan will cover a percentage of the Allowed Benefit for covered services you or your covered Dependents receive. You will usually pay 20% of the Allowed Benefit, and the Plan will pay 80%.

If you go Out-of-Network to a Non-Participating Provider, the Plan will pay a percentage of the cost for covered services, up to the Allowed Benefit. If your Non-Participating Provider charges more than the Allowed Benefit, you will be responsible for paying your percentage of the Allowed Benefit in addition to any charges above Allowed Benefit. This additional amount is *not* counted toward your Deductible or the annual out-of-pocket limit. Check the Schedule of Benefits for your Coinsurance for specific services.

Out-of-Pocket Limit

To protect you and your family from the cost of a catastrophic illness or accident, there is a limit on the amount of out-of-pocket medical expenses you will be expected to incur for covered services every calendar year. This is called the Out-of-Pocket Limit. After your costs reach the limit, the Plan will pay 100% of your covered medical costs. The following Out-of-Pocket Limits will apply:

	In-Network	**Out-of-Network**
Individual coverage	$1,000	$2,000
Family coverage	$2,000	$4,000

If you use a combination of In- and Out-of-Network services, the amount of money spent for each type of service can be combined to meet your Out-of-Pocket Limits.

If you have family coverage, eligible expenses of all covered members can be combined to meet your family Out-of-Pocket Limit. However, one covered Dependent cannot contribute more than the individual limit toward meeting the family limit.

Note: The following items do not contribute toward the Out-of-Pocket Limit:

- Charges above the Allowed Benefit for services rendered by non-Participating Providers.
- Penalties for failure to comply with the Utilization Management Program.
- Non-covered services.

- Services applied to the calendar year deductible.

Lifetime Maximum The Lifetime Maximum is Two Million Dollars ($2,000,000).

Filing a Claim If you see a Non-Participating Provider, you are responsible for filing a claim form, or for ensuring that your doctor's office or hospital files one for you. As previously discussed, if you see a Preferred Provider or Participating Provider, you will not need to file a claim.

Claim forms are available by calling Customer Service at 1-888-417-8385. Attach an itemized bill to your completed claim form and submit it to:

CareFirst BlueCross BlueShield
National Accounts Dedicated Services
P.O. Box 1739
Cumberland, MD 21501

Claims must be submitted to CareFirst within 15 months of the date the services or supplies were received. CareFirst will only consider claims beyond the 15-month filing limit if you are legally incapacitated.

You should keep copies of all bills for your records. Your original bills will not be returned.

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

PROGRAM DESCRIPTION

The Group reserves the right to change, modify, or terminate the Plan, in whole or in part.

Members have no benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

Members should not rely on any oral description of the Plan, because the written terms in the Group's Plan documents always govern.

To the extent that this health care benefits plan is completely or partially self-funded by the Group, CareFirst provides administrative services only and does not assume any financial risk or obligation with respect to health care benefit claims for the self-insured portion of the Contract.

SECTION 1
DEFINITIONS

1.1 This Program Description uses certain defined terms. When these words are capitalized, they have the following meanings.

Anniversary Date means the date specified in the Administrative Service Agreement (ASA), on which the Contract renews and each annual anniversary of such date.

Benefit Guide means the summary description of the program provided to all Members. In the event of a conflict between the summary description and this complete Program Description, the language of this Program Description governs.

CareFirst means Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield.

Claims Administrator means CareFirst.

Contract means the agreement issued by CareFirst to the Employee/Member's Group through which the benefits described in this Program Description are administered to the Employee/Member and his enrolled Dependents, if any. In addition to this Program Description, the Contract includes an Administrative Services Agreement, Attachments, any Riders or Amendments and the Benefit Guide.

Conversion Contract means a non-group health benefits contract issued in accordance with applicable federal, local and state laws and regulations to individuals whose coverage through the Group has terminated.

Dependent means a person who meets the eligibility rules in Section 2, Eligibility and Enrollment.

Domestic Partner means a person who meets the eligibility rules in Section 2, Eligibility and Enrollment.

Effective Date means the date on which the Group Contract becomes effective and on which Members first become eligible to receive benefits and services under the Contract. The Effective Date is set forth in the Administrative Services Agreement.

Eligible Employee/Member means persons who meet the eligibility rules in Section 2, Eligibility and Enrollment.

Enrollment Application/Form means the information submitted by or on behalf of an eligible individual in connection with a request to enroll under the Contract as either an Employee/Member or a Dependent.

Experimental or Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing excluding Clinical Trial Patient Cost Coverage as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

1. The Technology* must have final approval from the appropriate government regulatory bodies;

2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;

3. The Technology must improve the net health outcome;

4. The Technology must be as beneficial as any established alternatives; and,

5. The improvement must be attainable outside the Investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

Group Contract means the Contract issued by CareFirst to the Group/Sponsor.

Group/Sponsor means the Employee/Member's employer or other organization that sponsors a health benefits plan to which CareFirst has issued the Contract.

Hospital means any facility in which the primary function is the provision of diagnosis, treatment, and medical and nursing services, surgical or non-surgical and that is:

A. Licensed by the appropriate State authorities; or

B. Accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

C. Approved by Medicare.

The facility cannot be, other than incidentally: a convalescent home, convalescent rest or nursing facilities; facilities primarily affording custodial, educational or rehabilitative care; or facilities for the aged, drug addicts or alcoholics.

Limiting Age means the age to which a Subscriber may cover his/her unmarried Dependent Children as stated in Section 2, Eligibility and Enrollment.

Medical Director is a board-certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary (or Medical Necessity) means use of a service or supply that is:

1. Commonly and customarily recognized as appropriate in the diagnosis and treatment of a Member's illness or injury;

2. Appropriate with regard to standards of good medical practice;

3. Not solely for the convenience of the Member, his or her physician, hospital, or other Health Care Provider; and,

4. The most appropriate supply or level of service that can be safely provided to the Member.

The term "not Medically Necessary" means the use of a service or supply that does not meet the above criteria for determining medical necessity. The decision as to whether a service or supply is Medically Necessary for purposes of payment by CareFirst rests with the Medical Director or his/her designee; however, such a decision shall in no way affect the provider's/practitioner's determination of whether medical treatment is appropriate as a matter of clinical judgment.

Member means an individual who meets all applicable eligibility requirements and is enrolled either as a Subscriber or as a Dependent, and for whom the appropriate payments have been received by CareFirst.

Membership Categories are based upon whether the Employee/Member only or the

Employee/Member and Dependents are enrolled. In addition, Membership Categories may distinguish which Dependents are enrolled along with the Employee/Member.

Membership Categories under the Contract are:

- **Individual Coverage**, which covers the Employee/Member only;
- **Two-Party Coverage**, which covers the Employee/Member and either:
  - his Spouse; or
  - Domestic Partner; or
  - his Dependent Child
- **Family Coverage**, which covers the Employee/Member and two or more Dependents.

Additionally, **Retired** employees may elect one of the following:

- **Medicare Complementary** (entitled to Medicare Parts A & B): Coverage for Employee/Member only
- **Individual + 1 Medicare** (One person has Medicare coverage) Coverage for the Employee/Member and**:**
  - Spouse, Domestic Partner, eligible Adult Dependent, and or eligible Dependent Children; or
  - Eligible Dependent Child
- **Two Medicare Complementary** (both persons have Medicare coverage) Coverage for Employee/Member and:
  - Spouse, Domestic Partner or eligible Adult Dependent
  - Eligible Dependent Child

Paid Claims is the amount paid by CareFirst for Covered Services under the Plan. The following are also included in Paid Claims:

A. BlueCard Fees and Compensation;

B. Third-party vendor fees.

Plan means that portion of the Welfare Benefit Plan established by the Group that provides for health care benefits for which CareFirst is the Claims Administrator under this Group Contract.

Plan Administrator means the person or persons designated by the Group.

PPO Program Option or "Program" means the coverage that is available to Members who elect to enroll in the PPO Program Option through which Members may receive Covered Services from either an In-Network provider or from an Out-of-Network Provider. Benefits under the In-Network component of the PPO Program Option are available through a PPO Network arrangement operated by CareFirst.

Program Description means this document. In addition to this Program Description, the Contract includes an Administrative Services Agreement, Attachments, any Riders or Amendments and the Benefit Guide.

Subscriber means a Member who is covered under the Contract as an Employee/Member, rather than as a Dependent.

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Contract are selected by the Group and are stated in this Program Description. All types may not be available under a Group's Contract.

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage. The Group is required to administer all requirements for coverage in strict accordance with the terms that have been agreed to and cannot change the requirements for coverage or make an exception unless CareFirst approves them in advance, in writing. To be covered under the Contract, all of the following conditions must be met:

A. The individual must be eligible for coverage either as an Employee/Member pursuant to Section 2.2, below or, if applicable, as a Spouse, Domestic Partner or Dependent pursuant to Section 2.3 or 2.4 below;

B. The individual must elect coverage during certain periods set aside for this purpose as described in Section 2.6, below;

C. The Group must notify CareFirst of the election in accordance with the Group Contract; and

D. Payments must be made by or on behalf of the Member as required by the Group Contract.

2.2 Eligibility as an Employee/Member. To be eligible as an Employee/Member, the individual must meet the basic requirements as stated below and any additional eligibility requirements to which the Group has agreed. These are set below and in the Group Application (available through your Group).

A. Basic Plan Requirements. You must be a permanent active or retired employee of the Group or of one of the participating agencies of the Group, or in a class of temporary employees eligible for benefits.

B. Additional Eligibility Requirements. In addition to the basic eligibility requirements in Section 2.2.a., above, you must meet the additional eligibility requirements that are listed in the Group Application. The Group is required to administer these requirements in strict accordance with the terms that have been agreed to and cannot change the requirements or make an exception unless we approve them in advance, in writing.

2.3 Eligibility of Employee/Member's Spouse or Domestic Partner. An Employee/Member may elect Family or Subscriber and Spouse or Domestic Partner Coverage; an Employee/Member may cover his/her legal spouse or Domestic Partner as a Dependent. An Employee/Member cannot cover a former spouse once divorced or if the marriage has been annulled. If an Employee/Member is separated but still legally married, his or her spouse may still be covered.

2.4 Eligibility of Employee/Member's Dependent Children. The Group may elect to provide coverage for eligible Dependent Children. To be eligible as a Dependent Child, the child must:

A. Meet the age requirements described in Section 2.5 below;

B. Be unmarried; and

C. Be related to the Employee/Member, in one of the following ways:

1. A natural child;

2. A legally adopted child or grandchild;

3. A child (including a grandchild) for whom the Employee/Member is the legally recognized proposed adoptive parent and who is dependent upon and living with the Employee/Member during the waiting period before the adoption becomes final;

4. A stepchild who permanently resides in the Employee/Member's household and who is dependent upon the Employee/Member for more than half of his or her support;

5. A grandchild who is in the court ordered custody of and is dependent upon and residing with the Employee/Member;

6. A child for whom the Employee/Member has been court ordered or administratively ordered to provide coverage;

7. Children whose relationship to the Employee/Member are not listed above, are not covered under the Contract, even though the child may live with the Employee/Member and be dependent upon the Employee/Member for support. CareFirst has a right to request documentation from the Employee/Member that a child qualifies for coverage as a Dependent.

8. The child of the Employee/Member's Domestic Partner who permanently resides in the Employee/Member's household and is dependent upon the Employee/Member, for more than half of his or her support.

2.5 Age Limits for Coverage of Dependent Children (Limiting Age). All Dependent Children are eligible for coverage up to the Limiting Age for non-students, as stated below:

Dependent Children may be eligible beyond the Limiting Age if they meet the requirements for Student Dependents, as described below:

A. All Dependent Children are eligible up to age 19;

B. Children who are age 19 or over are eligible up to age 26 if attending an accredited school, college or university on a full time basis. Student Dependent means a Dependent Child whose attendance at an accredited institution at which he/she is enrolled meets the institution's requirements for full time status. The Member must provide CareFirst with proof of the child's student status, within 31 days after the child's 19th birthday, or coverage would otherwise terminate or within 31 days after the Effective Date of the child's coverage under the Contract, whichever is later. CareFirst has the right to verify whether the child is and continues to qualify as a Dependent or Student Dependent.

C. A Dependent Child will be eligible for coverage past the Limiting Age of 19 if:

1. The child is incapable of supporting him or herself because of mental or physical disability;

2. The disability occurred before the child reached the Limiting Age or, if the child was covered beyond the Limiting Age as a non-Student or Student Dependent, the disability occurred before the child reached the Limiting Age;

3. The child is primarily dependent upon the Employee/Member or the Employee/Member's spouse or Domestic Partner for support and

maintenance; and

4. The Member provides CareFirst with proof of the child's certified medical incapacity, within 31 days after the child's coverage would otherwise terminate or within 31 days after the Effective Date of the child's coverage under the Contract, whichever is later. CareFirst has the right to verify whether the child is and continues to qualify as an incapacitated child.

2.6 Enrollment Requirements. Eligible individuals may elect coverage as Employee/Members or Dependents, as applicable, only during the following times and under the following conditions:

A. **Annual Open Enrollment**. Prior to January 1 of each year that the Group Contract is in effect, the Group will have an Open Enrollment Period as announced by the Group. During the Open Enrollment Period, Eligible Subscribers who are not covered may enroll themselves and their Dependents in the Plan. In addition, enrolled Subscribers may change their Type of Coverage and/or add eligible Dependents not previously enrolled to their coverage, or change plan options. Your coverage will become effective on January 1.

B. **Newly Eligible Employee/Member**. Newly eligible individuals may enroll within 31 days after they first become eligible as determined within Section 2, Eligibility and Enrollment. If such individuals do not enroll within this period and do not qualify for the Special Enrollment Period as described in Section 2.6.F, Special Enrollment Periods, they must wait for the Group's next open enrollment period.

C. **Coverage of a Newborn, Newly Adopted Child, Newly Eligible Grandchild or a Minor to whom Guardianship is granted by Court or Testamentary Appointment**. Employee/Members may enroll new family members, such as an eligible newborn child, newly adopted child, newly eligible grandchild or a minor for whom guardianship is granted by court or testamentary appointment and/or change their Membership Category to include the new family member within 31 days following the date the new family member first becomes eligible. If this election is not made within this period and the new family member does not qualify for the Special Enrollment Period as described in Section 2.6.F, the new family member(s) may not enroll until the Group's next open enrollment period. The date of the child's First Eligibility Date is defined below:

First Eligibility Date:

1. For a newborn child, the child's date of birth;

2. For a newly adopted child, the earlier of; a judicial decree of adoption; or date of assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent;

3. For a grandchild for whom the Employee/Member has been granted legal custody, the date of the court decree or the date the court decree becomes effective, whichever is later;

4. For a minor for whom guardianship has been granted by court or testamentary appointment, the date of the appointment.

Family Coverage. If the Employee/Member is already enrolled under Family Coverage on the child's First Eligibility Date, an eligible newborn child, newly adopted child, newly eligible grandchild or a minor for whom guardianship has been granted by court or testamentary appointment will be covered automatically

as of the child's First Eligibility Date.

Individual Coverage. If the Employee/Member is enrolled under Individual Coverage on the child's First Eligibility Date, the child will be covered automatically, but only for the first 31 days following the child's First Eligibility Date. The Employee/Member may continue coverage beyond this 31 day period, but the Employee/Member must enroll the child within 31 days following the child's First Eligibility Date. Premium changes resulting from the addition of the child will be effective as of the child's First Eligibility Date.

Two-Party Coverage. If the Employee/Member is enrolled under Two-Party coverage (e.g., Employee and spouse or Domestic Partner or Employee and one child) on the child's First Eligibility Date, the child will be covered automatically as of the child's First Eligibility Date. However, if adding the child to the coverage results in a change in the Employee/Member's Membership Category (e.g., from Two-Party coverage to Family Coverage), the child's automatic coverage will end on the 31st day following the child's First Eligibility Date. If the Member wishes to continue coverage beyond this 31 day period, they must enroll him or her within 31 days following the First Eligibility Date. The change in the Membership Category and corresponding premium for the Employee/Member's new Membership Category will be made effective as of the child's First Eligibility Date.

D. **New Family Member (Other than a newborn or newly adopted child or newly eligible grandchild or a minor to whom guardianship is granted by court or testamentary appointment).** The Employee/Member may enroll new family members, such as a new spouse, Domestic Partner or stepchild, and/or change the Membership Category to include the new family member within 31 days following the date the new family member first becomes eligible. If this election is not made within this period and the new family member does not qualify for the Special Enrollment Period as described in Section 2.6.F, the new family member(s) may not enroll until the Group's next open enrollment period.

First Eligibility Date:

1. Spouse - The date the marriage is legally recognized.

2. Domestic Partner - The date established by the Group's enrollment procedures.

3. Stepchild or child of a Domestic Partner - If the child meets the definition of a Dependent Child under Section 2.4, the First Eligibility Date will be the same as that of the spouse or Domestic Partner. Otherwise, the First Eligibility Date for the child will be the date on which the child first meets the definition of Dependent Child under Section 2.4.

E. **Coverage of Children under Court or Administrative Order**. If the Employee/Member has been ordered by a court or administrative agency to provide coverage under this Contract for his or her Dependent child (or children), the Employee/Member may enroll the eligible minor Dependent child (or children) included in the order within 31 days following the date on which the order was signed by a competent court or administrative agency. If the Group is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Group will determine whether an order received by the Group with respect to employees of the Group and their children is a "qualified medical child support order" (as that term is defined under ERISA) and whether such children are eligible for coverage under that qualified medical support order.

F. **Special Enrollment Periods.** Special enrollment is allowed for certain individuals who lose coverage. Special enrollment is also allowed with respect to certain Dependent beneficiaries.

If only the Subscriber is eligible under this Contract and Dependents are not eligible to enroll, special enrollment periods for a spouse/Dependent child are not applicable.

1. Special enrollment for certain individuals who lose coverage:

   a. CareFirst will permit current employees and Dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Contract.

   b. Individuals eligible for special enrollment.

      1) When employee loses coverage. A current employee and any Dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:

         a) The employee and the Dependents are otherwise eligible to enroll;

         b) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

         c) The employee satisfies the conditions of paragraph 1.c)1), 2), or 3) of this section, and if applicable, paragraph 1.c)5) of this section.

      2) When Dependent loses coverage.

         a) A Dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit packaged offered by the Group (subject to Group eligibility rules conditioning Dependent enrollment on enrollment of the employee) if:

            i) The Dependent and the employee are otherwise eligible to enroll;

            ii) When coverage was previously offered, the Dependent had coverage under any group health plan or health insurance coverage; and

            iii) The Dependent satisfies the conditions of paragraph 1.c)1), 2), or 3) of this section, and if applicable, paragraph 1.c)4) of this section.

         b) However, CareFirst is not required to enroll any

other Dependent unless the Dependent satisfies the criteria of this paragraph 1.b)2), or the employee satisfies the criteria of paragraph 1.b)1) of this section.

c. Conditions for special enrollment.

1) Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph 1)c)1) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage. Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:

a) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;

b) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

c) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual;

d) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

e) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.

2) Termination of employer contributions. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or Dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.

3) Exhaustion of COBRA continuation coverage. In the case of an employee or Dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph 1)c)1) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.

4) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any Dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any Dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or Dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)

2. Special enrollment with respect to certain Dependent beneficiaries:

a. Provided the Group provides coverage for Dependents, CareFirst will permit the individuals described in paragraph 2.b. of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Contract.

b. Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph 2.b)1), 2), 3), 4), 5), or 6) of

this section.

1) Current employee only. A current employee is described in this paragraph if a person becomes a Dependent of the individual through marriage, birth, adoption, or placement for adoption.

2) Spouse of a participant only. An individual is described in this paragraph if either:

   a) The individual becomes the spouse of a participant; or

   b) The individual is a spouse of a participant and a child becomes a Dependent of the participant through birth, adoption, or placement for adoption.

3) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:

   a) The employee and the spouse become married; or

   b) The employee and spouse are married and a child becomes a Dependent of the employee through birth, adoption, or placement for adoption.

4) Dependent of a participant only. An individual is described in this paragraph if the individual is a Dependent of a participant and the individual has become a Dependent of the participant through marriage, birth, adoption, or placement for adoption.

5) Current employee and a new Dependent. A current employee and an individual who is a Dependent of the employee, are described in this paragraph if the individual becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.

6) Current employee, spouse, and a new Dependent. A current employee, the employee's spouse, and the employee's Dependent are described in this paragraph if the Dependent becomes a Dependent of the employee through marriage, birth, adoption, or placement for adoption.

2.7 Effective Dates. Coverage for an Employee/Member or his or her Dependents will become effective as stated below as long as the Enrollment Requirements in Section 2.6 are satisfied.

A. **Open Enrollment Effective Date**. Enrollment or changes in enrollment will be effective January 1, 2006, which is the Group's Open Enrollment Effective Date/Anniversary Date, if the requirements of Section 2.6.A are met.

B. **New Employee/Members.** Coverage of new Employee/Members will be made effective on the as determined by the Employee/Members Office of Human Resources if the requirements of Section 2.6.B are met.

C. **Coverage of Newborn Children, Newly Adopted Children and Newly Eligible Grandchildren**. Coverage will become effective as of the child's First Eligibility Date as stated in Section 2.6.C, if the requirements of Section 2.6.C are met.

D. **Coverage of Other Newly Eligible Dependents**. Coverage of other newly eligible Dependents; e.g., a new spouse, Domestic Partner, stepchild or child of a Domestic Partner, will be made effective in accordance with the Eligibility Date stated in Section 2.6., provided the newly eligible Dependent is enrolled within 31 days following the date upon which the Dependent first became eligible.

E. **Coverage of Children under Court or Administrative Order**. Coverage of the Dependent Child under a court or administrative order will become effective on the first day of the month following our receipt of the Enrollment Form or as otherwise required by the court or administrative order or applicable law as stated in Section 2.6.E, if the requirements of Section 2.6.E are met.

2.8 Employee/Member's Coverage Changes. When the Employee/Member's Membership Category is changed (e.g., from Individual to Family coverage) the change may become effective on any day throughout the month. Charges for Members enrolled during the month will be calculated on a pro-rata basis unless otherwise agreed to between the Group and CareFirst.

2.9 Domestic Partner Eligibility. The Group and CareFirst may require proof of any of the following qualifications at any time:

A. **Eligibility of Employee/Member's Domestic Partner**. The following persons are also eligible for benefits under the Contract:

1. The Subscriber's Domestic Partner.

2. The Eligible Dependents of a Domestic Partner.

A Domestic Partner and the Eligible Dependents of a Domestic Partner remain eligible only for the period that the Domestic Partnership continues.

A person who is related to the Subscriber; e.g., parent, grandparent, sibling, cousin, aunt, uncle, etc. is not eligible.

B. **Definitions**

Domestic Partner is a person who cohabitates/resides with the Subscriber in a Domestic Partnership and the Eligible Dependents of a Domestic Partner.

Eligible Dependent of a Domestic Partner is an unmarried person who has the same relationship to a Domestic Partner that is required of an Employee/Member's Dependent Children as defined herein.

Domestic Partnership is a relationship between a Domestic Partner and a Subscriber both of whom have signed the appropriate affidavit, enrollment application, or other document(s) required by the Group confirming their Domestic Partnership and that satisfies the following requirements:

1. They are the same sex (or opposite sex for members of the FOP, effective July 1, 2001 and for members of the IAFF, effective July 1, 2002);

2. They share a close personal relationship and be responsible for each other's welfare;

3. They have shared the same legal residence for at least 12 months;

4. They are a least 18 years old;

5. They have voluntarily consented to the relationship, without fraud or duress;

6. They are not married to, or in a domestic partnership with, any other person;

7. They have not related by blood or affinity in a way that would disqualify them from marriage under State law if the employee and partner were opposite sexes;

8. They are legally competent to contract;

9. They share sufficient financial and legal obligations; or

10. They have legally registered the Domestic Partnership, if

    - A Domestic Partnership registration system exist in the jurisdiction where the employee resides; and

    - The Office of Human Resources determines that the legal requirements for registration are substantially similar to the requirements listed under 1 above.

The Employee/Member must provide evidence of the Domestic Partnership. The Employee/Member must provide the following:

1. The Affidavit For Domestic Partnership signed in the presence of a notary public by both the Employee/Member and the Employee/Member's Domestic Partner under penalty of perjury declaring that they satisfy the requirements of Domestic Partnership; or

2. An official copy of the Domestic Partnership registration.

   and;

3. Evidence that the Employee/Member and the Domestic Partner share items described in at least 2 of the following (this requirement does not apply to a qualified, registered domestic partnership):

    - Joint housing lease, mortgage, or deed;

    - Joint ownership of a motor vehicle;

    - Joint checking or credit account;

    - Designation of the partner as the primary beneficiary of the employee's life insurance, retirement benefits, or residuary estate under a will; or;

- Designation of the partner as holding a durable power of attorney for health care decisions regarding the employee.

C. **Enrollment Requirements and Effective Date**. A Domestic Partner must

1. File a notarized Affidavit For Domestic Partnership, with all required supporting evidence with the Office of Human Resources (affidavit form is attached);

2. Within 60 days of filing the affidavit with all required supporting evidence,

   - Complete a benefit enrollment form, when changing your level of coverage due to the addition of the Domestic Partner and Eligible Dependents of a Domestic Partner;

   - Complete a dependent information form to add the Domestic Partner and Eligible Dependents of a Domestic Partner (Note - Proof of eligibility, such as a birth certificate, is required to add Eligible Dependents of a Domestic Partner to the group insurance plans); and

   - Complete any forms required by the group insurance plan to add Eligible Dependents of a Domestic Partner.

Eligible Dependents of a Domestic Partner are enrolled in the same manner as a child and will have the same Effective Dates as a child.

D. Termination of Coverage. The Subscriber agrees to notify the Group in writing of the termination of the Domestic Partnership within 30 days of the date of termination. In such case, benefits will terminate or continue for the Domestic Partner and any Eligible Dependents of a Domestic Partner as they would for any other Member.

E. **Continuation Privilege**. A Domestic Partner and the Eligible Dependents of a Domestic Partner are eligible for Continuation of Coverage under Federal Law.

F. **Conversion Privilege**. A Domestic Partner and the Eligible Dependents of a Domestic Partner are eligible for the Conversion Privilege of the Contract.

SECTION 3
MEDICAL CHILD SUPPORT ORDERS

3.1 Definitions

A. **Medical Child Support Order** means an "order" issued in the format prescribed by federal law; and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An "order" means a judgment, decree or a ruling (including approval of a settlement agreement) that:

1. is issued by a court or administrative child support enforcement agency of any state or the District of Columbia; and

2. Creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage; or establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

B. **Qualified Medical Support Order ("QMSO")** means a Medical Child Support Order issued under State law, or the laws of the District of Columbia, and when issued to an employer sponsored health plan.

3.2 Eligibility and Termination.

A. Upon receipt of a QMSO, when coverage of the Subscriber's family members is available under the terms of the Subscriber's contract then CareFirst will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any State or the District of Columbia. If the Subscriber has not completed any applicable waiting periods for coverage, the child will not be enrolled until the end of the waiting period.

The Subscriber must be enrolled under this contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions.

B. Enrollment for such a child will not be denied because the child:

1. Was born out of wedlock.

2. Is not claimed as a dependent on the Subscriber's federal tax return.

3. Does not reside with the Subscriber.

4. Is covered under any Medical Assistance or Medicaid program.

C. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to a QMSO may not be terminated unless written evidence is provided to CareFirst that:

1. The QMSO is no longer in effect;

2. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage; or,

3. If coverage is provided under an employer sponsored health plan;

    a. The employer has eliminated family member coverage for all employees; or

    b. The employer no longer employs the Subscriber, except if the Subscriber elects continuation under applicable State or federal law the child will continue in this post-employment coverage.

3.3 Administration. When the child subject to a QMSO does not reside with the Subscriber, CareFirst will:

A. Send the non-insuring custodial parent ID cards, claim forms, the applicable certificate of coverage or member contract and any information needed to obtain benefits;

B. Allow the non-insuring custodial parent or a provider of a covered service to submit a claim without the approval of the Subscriber;

C. Provide benefits directly to:

1. The non-insuring parent;

2. The provider of the covered services; or

3. The appropriate child support enforcement agency of any State or the District of Columbia.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Member Coverage by CareFirst.

A. CareFirst can terminate coverage if CareFirst determines:

1. The Member allowed another person to use his/her identification card or the Member used another person's identification card. The identification card must be returned to CareFirst upon request.

2. The Member made an intentional misrepresentation of information which was material to the acceptance of the application when the Member represented that all information contained in the Enrollment Application was true, correct and complete to the best of the Member's knowledge and belief.

3. The Member made an intentional misrepresentation of any information required by CareFirst on any forms or other written requests for data. Such information will include but not be limited to requests for medical information, coordination of benefits information, subrogation information, employment status and dependent eligibility status.

4. The Member or the Member's representative made fraudulent misstatements related to coverage or benefits under the Contract.

4.2 Termination of Coverage by the Employee/Member.

A. The Employee/Member can remove an eligible Dependent if the Employee/Member makes a written request to the Group, at least 31 days prior to the requested termination date.

B. CareFirst shall not be required to give notice of termination to the Employee/Member or Dependents as a result of the Employee/Member's written request for termination.

C. Except as otherwise provided all Employee/Member benefits under the Contract will end as stated below.

a. Coverage for all Members under this Contract will terminate on as determined by the Employee/Members Office of Human Resources.

b. Coverage for all Members under this Contract will terminate as determined by the Employee/Members Office of Human Resources.

2. If the Subscriber remains eligible for coverage under this Contract, but another Member's eligibility ceases:

a. Coverage under this Contract will terminate as determined by the Employee/Members Office of Human Resources.

b. Coverage for a Dependent Child will terminate as determined by the Employee/Members Office of Human Resources.

c. Coverage for a Student Dependent will terminate as determined

by the Employee/Members Office of Human Resources.

d. Coverage for a Student Dependent will terminate as determined by the Employee/Members Office of Human Resources.

4.3 Loss of Eligibility as a Dependent. Coverage of Dependents will automatically terminate when the Dependent reaches the Limiting Age or there is a change in the Dependent's status or relationship to the Employee/Member such that the Dependent no longer meets the eligibility requirements of the Contract. Termination of Coverage of Dependents due to loss of eligibility will be effective as stated in Section 2, Eligibility and Enrollment.

A. It is the Employee/Member's responsibility to notify the Group, and the Group's responsibility to notify CareFirst, of any changes in the status of his/her Dependents that affect their eligibility for coverage under the Contract.

B. If the Employee/Member does not notify the Group, and the Group does not notify CareFirst, and it is later determined that a Dependent was not eligible for coverage, CareFirst has the right to recover the full value of the services and benefits provided during the period of ineligibility. CareFirst can recover these amounts from the Employee/Member or from the Dependent, at CareFirst's option.

4.4 Death of an Employee/Member. In the event of the Employee/Member's death, coverage of any Dependents will continue, under a newly assigned identification, as determined by the Employee/Members Office of Human Resources.

4.5 Reinstatement Requires Application. If coverage of any Member is cancelled or terminated for any reason, coverage may be renewed only if the individual reestablishes eligibility and submits an application in accordance with Section 2, Eligibility and Enrollment. Coverage will not reinstate automatically, under any circumstances.

4.6 Continuation of Coverage under COBRA. This provision applies if the group plan is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time (COBRA) and the Members coverage terminates due to a "Qualifying Event" as described under COBRA. A Member may elect to continue the Member's coverage under the Group Contract to the extent and for the time period permitted by COBRA. The Sponsor of the group plan is the Plan Administrator. It is the Plan Administrator's responsibility to notify the Member whether COBRA applies and, if so, the terms, conditions and rights that apply to the Member under COBRA. The Member should contact the Plan Administrator if the Member has any questions regarding the Member's rights under COBRA.

4.7 Extension of Benefits for the Point-of-Service (In-Network benefits only) Program Option. If a Member is confined in an institution in which benefits are covered under this Contract on the date this Contract terminates (unless termination is due to failure to pay a premium when otherwise eligible to do so), CareFirst will continue to provide the benefits described in this Contract, until the earliest of the following:

A. The date the confinement ceases;

B. The date the Member is no longer, in the judgment of CareFirst's Medical Director, or his or her designee, medically required to continue care as an inpatient; or

C. 90 days following termination.

4.8 Extension of Benefits for the Point-of-Service (Out-of-Network benefits only) Program Option.

A. If a Member is Totally Disabled when his/her coverage terminates, CareFirst shall continue to pay covered benefits, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for expenses incurred by the Member for the condition causing the disability until the earlier of:

1. The date the Member ceases to be Totally Disabled; or

2. 12 months after the date coverage terminates.

Same Age Group means within the age group including persons three years older and younger than the age of the person claiming eligibility as Totally Disabled.

Substantial Gainful Activity means the undertaking of any significant physical or mental activity that is done (or intended) for pay or profit.

Totally Disabled (or Total Disability) means a condition of physical or mental incapacity of such severity that an individual, considering age, education, and work experience, cannot engage in any kind of Substantial Gainful Activity or engage in the normal activities as a person of the Same Age Group. A physical or mental incapacity is an incapacity that results from anatomical, physiological, or psychological abnormality or condition, which is demonstrable by medically accepted clinical and laboratory diagnostic techniques. CareFirst reserves the right to determine whether a Member is and continues to be Totally Disabled.

B. If a Member is confined in a hospital on the date that the Member's coverage terminates, CareFirst shall continue to pay covered benefits, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for the confinement until the earlier of:

1. The date the Member is discharged from the hospital; or

2. 12 months after the date coverage terminates.

If the Member is Totally Disabled upon his/her discharge from the hospital, the extension of benefits described in paragraph A., above applies; however, an additional 12-month extension of benefits is not provided. An individual is entitled to only one 12-month extension, not an inpatient 12-month extension and an additional Totally Disabled 12-month extension.

C. This section does not apply if:

1. Coverage is terminated because an individual fails to pay a required Premium;

2. Coverage is terminated for fraud or material misrepresentation by the individual.

4.9 Conversion Privilege. Members whose coverage under the Contract terminates may be eligible for conversion coverage. Eligibility for conversion coverage is described in Section 5 of this Program Description.

SECTION 5
CONVERSION PRIVILEGE

5.1 Conversion Privilege.

A. **Group Conversion**. All Members covered under the Contract whose coverage is terminated for any reason except those listed in Section 5.1.B below are eligible to apply for a Conversion Contract. The Member must apply within 31 days of the termination date.

B. **When Conversion Coverage Is Not Provided**. A Member is not eligible for a conversion contract if the Member:

1. Is eligible for or covered by Medicare;

2. Is eligible for or covered by substantially the same level of hospital, medical, and surgical benefits under state or federal law;

3. Is covered by substantially the same level of hospital, medical, and surgical benefits under any policy, contract, or plan for individuals or groups;

4. Has not been continuously covered during the 3 month period immediately preceding the terminating event; or,

5. Was terminated from the Contract for:

   a. Failure to pay the premium or Copayments;

   b. Fraud or deception in the use of services or facilities;

   c. Violation of the terms of the prior contract; or,

   d. For other good cause as specified in the Contract.

5.2 Application for Conversion Contracts. A Member who is entitled to continue coverage through a Conversion Contract should contact CareFirst as soon as possible after coverage terminates to request an application form and a schedule of premiums. Benefits under a Conversion Contract may vary from the benefits under the Contract and CareFirst reserves all rights, subject to applicable requirements of law, to determine the form and terms of the Conversion Contract(s) to be issued.

A. CareFirst must receive a completed application from the Member, including full payment of the first premium, within 31 days after the effective date of termination.

B. Conversion Contracts issued under this Section will not require evidence of insurability.

C. In no case will enrollment be denied based on the health status of the Member; or, for exercising complaint and grievance rights under the Contract.

5.3 Effective Date of Conversion Contract. A Conversion Contract issued under this Section will be effective on the day following the date the Contract terminated or the Member's coverage under the Contract terminated.

SECTION 6
MULTIPLE COVERAGE

6.1 Coordination Of Benefits ("COB").

A. **Applicability**

1. This Coordination of Benefits ("COB") provision applies to CareFirst when a Member has health care coverage under more than one Plan. " Plan " and "CareFirst" are defined below.

2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of CareFirst are determined before or after those of another Plan.

The benefits for CareFirst:

a. Shall not be reduced when, under the order of determination rules, CareFirst determines its benefits before another Plan; but

b. May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is described in the "Effect on Benefits" Section below.

B. **Terms.** For the purpose of this COB Section, the following terms are defined. The definitions of other capitalized terms are found in the Definitions Section of This Certificate.

1. **Plan**: any health insurance policy, including those of nonprofit health service Plan's, and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim.

The term Plan includes coverage under a governmental Plan, or coverage required or provided by law. This does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

The term Plan does not include:

a. an individually underwritten and issued, guaranteed renewable, specified disease policy;

b. an intensive care policy, which does not provide benefits on an expense incurred basis;

c. coverage regulated by a motor vehicle reparation law;

d. the first $100 per day of a Hospital indemnity contract; or,

e. an elementary and or secondary school insurance program sponsored by a school or school system.

An "intensive care policy" means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

A "specific disease policy" means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

2. **CareFirst**: Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield.

3. **Primary Plan Or Secondary Plan**: the order of benefit determination rules state whether CareFirst is a Primary Plan or Secondary Plan as to another Plan covering the Member.

   When CareFirst is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When CareFirst is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the Member, this CareFirst may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expenses**: a health care service or expense, including deductibles, coinsurance or copayments, that is covered at least in part by any of the Plans covering the Member, except as set forth below. This means that an expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense. When a Plan provides benefits in the form of services, (for example an HMO or a Closed Panel Plan) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

5. **Claim Determination Period**: A calendar year unless a different benefit year basis is specifically stated in the Schedule of Benefits. However, it does not include any part of a year during which a Member has no coverage under CareFirst, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **Closed Panel Plan** means a Plan that provides health benefits to Members primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

C. **Order Of Determination Rules**

1. **General**. When there is a basis for a claim under CareFirst and another Plan, CareFirst is a Secondary Plan which has its benefits determined

after those of the other Plan, unless;

a. The other Plan has rules coordinating benefits with those of CareFirst; and

b. Both those rules and CareFirst rules, in subsection 2. below, require that CareFirst benefits be determined before those of the other Plan.

2. **Rules**. CareFirst determines its order of benefits using the first of the following rules which applies:

a. Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1) Secondary to the Plan covering the person as a dependent, and

2) Primary to the Plan covering the person as other than a dependent (e.g. retired employee),

Then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

b. Dependent child/parents not separated or divorced. Except as stated in paragraph 2.c, below, when CareFirst and another Plan cover the same child as a dependent of different persons, called "parents:"

1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

2) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in 1) immediately above, but instead has a rule based upon the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. Dependent child/parents separated or divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1) First, the Plan of the parent with custody of the child;

2) Then, the Plan of the spouse of the parent with the custody of the child; and

3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child follow the order of benefit determination rules outlined in paragraph 2.b.

e. Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule e. is ignored.

f. Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to Federal or State law also is covered under another Plan, the following shall be the order of benefits determination:

1) First, the benefits of a Plan covering the person as an employee, member or Subscriber (or as that person's dependent);

2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

g. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter term.

D. **Effect on Benefits**

1. **When this Section applies**. This Section applies when, in accordance with the prior Section, order of benefits determination rules, CareFirst is a Secondary Plan as to one or more other Plans. In that event the benefits of CareFirst may be reduced under this Section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

2. **Reduction in CareFirst's Benefits**. The benefits under CareFirst will be reduced when the sum of:

   a. the benefits that would be payable for the Allowable Expense under CareFirst in the absence of this COB provision; and

   b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of CareFirst will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

   When the benefits of CareFirst are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of CareFirst.

E. **Right To Receive And Release Needed Information**

Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under CareFirst must give CareFirst any facts it needs to pay the claim.

F. **Facility Of Payment**

A payment made under another Plan may include an amount, which should have been paid under CareFirst. If it does, CareFirst may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under CareFirst. CareFirst will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

G. **Right Of Recovery**. If the amount of the payments made by CareFirst is more that it should have paid under this COB provision, it may recover the excess from one or more of:

1. the persons it has paid or for whom it has paid;

2. insurance companies; or,

3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any

benefits provided in the form of services.

6.2 **Medicare Eligibility**. This provision applies to Members who are enrolled in Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of 65 or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in the evidence of coverage. Benefits that are covered by Medicare are subject to the provisions in this Part.

A. **Coverage Secondary to Medicare**. Except where prohibited by law, the benefits under CareFirst plan are secondary to Medicare.

B. **Medicare as Primary**.

1. When benefits for Covered Services are paid by Medicare as primary, CareFirst will not duplicate those payments. When CareFirst coordinates the benefits with Medicare, CareFirst payments will be based on the Medicare allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare).

2. Benefits under CareFirst will be coordinated as described above to the extent a benefit would have been provided or payable under Medicare if the Member had diligently sought to establish his or her right to such benefits. Members shall agree to complete and submit to Medicare, CareFirst and/or Contracting Providers all claims, consents, releases, assignments and other documents required to obtain or assure such payment.

6.3 **Employer or Governmental Benefits.**

Coverage under CareFirst does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a "Benefit" (as defined below) is provided or is required to be provided either:

A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or

B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, but excluding Medicare benefits and Medicaid benefits.

Benefit defined. As used in this provision, "benefit" includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

6.4 **Subrogation**.

Subrogation applies when a Member has an illness or injury for which a third party may be liable. Subrogation requires the Member in certain circumstances to turn over to CareFirst any rights the Member may have against a third party.

A. The Member shall notify CareFirst as soon as reasonably possible and no later than the time the Member provides proof of a claim that a third party may be liable for the injuries or illnesses for which benefits are being paid.

B. To the extent that benefits are paid under this Contract, CareFirst shall be subrogated and succeed to any right of recovery of the Member against any person or organization.

C. The Member shall pay to CareFirst the amount recovered by suit, settlement, or otherwise from any third party or third party's insurer, or uninsured or underinsured motorist coverage, to the extent of the benefits paid under this Contract.

6.5 Personal Injury Protection ("PIP") Coverage.

PIP is insurance coverage without regard to fault provided under a Member's motor vehicle casualty insurance.

CareFirst will not reduce, limit, or exclude coverage due to payments made to the Member under the Member's PIP Policy.

SECTION 7
APPEALS AND GREIVANCE

CareFirst's appeal procedure is designed to enable you to have your concerns regarding a denial of benefits or authorization for services heard and resolved. By following the steps outlined below, you can ensure that your appeal is quickly and responsively addressed.

An expedited appeal process has been established in the event that a delay in a decision would be detrimental to your health or the health of a covered family member. In an expedited appeal, a decision by CareFirst shall be made within 24 hours, and review will be done by a peer of the patient's treating healthcare provider, if additional information would not change the Plan's decision. Expedited Appeals involve care that has not yet occurred or is currently occurring. (Pre Service or concurrent care).

Step 1: Discussion of the Problem

Your concerns can often be handled and resolved through informal discussions and information gathering. If your question relates to our handling of a claim or other administrative action, call and discuss the matter with a CareFirst member services representative. In many instances, the matter can be quickly resolved.

Step 2: Appeal/ Grievance Process

If your concern is not resolved through a discussion with a CareFirst representative, you or someone on your behalf may make a formal request for appeal. CareFirst must receive the request within 180 days or six months of the date of the notification of denial of benefits or services. If the request for appeal is related to a medical issue, a peer of the patient's treating health care provider, not part of the original denial decision, will review the request. This request should be in writing and addressed to the Member Services Department, and shall state the reason of the request. A Member Services representative will be available to assist you in submitting your appeal in the event you are unable to put the request in writing. All appeal decisions will be rendered in writing to the member, and include a detailed explanation as to the reason for the decision, and any supporting documentation to show how that decision was made. Included in this written appeal decision will be an explanation of the appropriate next steps a member may take if they are not satisfied with the appeal decision.

SECTION 8
GENERAL PROVISIONS

8.1 No Assignment. A Member cannot assign any benefits or payments due under the Contract to any person, corporation or other organization, except as required by law.

8.2 Payments Under the Contract. Payments for covered services will be made by CareFirst directly to Participating Providers. If a Member receives covered services from Non-Participating Providers, CareFirst reserves the right to pay either the Member or the provider and such payment shall, in either case, constitute full and complete satisfaction of CareFirst's obligation.

8.3 Claim Payments Made in Error. The Member is liable for any amount paid to a Member by CareFirst by mistake or in error on behalf of a Member.

8.4 Time Period for Filing Claims. All claims for covered services and supplies must be submitted to CareFirst or its designee within the timely filing periods that are listed below.

A. Medical Claims – fifteen (15) months after the date the services were rendered or supplies were received.

CareFirst or its designee will only consider claims beyond the filing period if the Member becomes legally incapacitated prior to the end of the filing period.

8.5 Member Statements. Except in the instance of fraud, all statements made by Members shall be considered representations and not warranties and no such statement shall be the basis for avoiding coverage or denying a claim after coverage has been in force for two years from its Effective Date, unless the statement was material to the risk and was contained in a written application.

8.6 Identification Card. Any cards issued to Members are for identification only.

A. Possession of an identification card confers no right to benefits under the Contract.

B. To be entitled to such benefits under the Contract, the holder of the card must, in fact, be a Member on whose behalf all applicable charges have actually been paid.

C. Any person receiving benefits to which he or she is not then entitled under the Contract will be liable for the actual cost of such benefits.

8.7 Member Medical Records. It may be necessary to obtain Member medical records and information from hospitals, skilled nursing facilities, physicians or other practitioners who treat the Member. When a Member becomes covered under the Contract, the Member (and if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst permission to obtain and use such records and information, including medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.

8.8 Privacy Statement. CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health-related data. In that regard, CareFirst will not provide to the plan sponsor named herein or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

8.9 CareFirst's Relationship to the Group. The Group is not an agent or representative of CareFirst and is not liable for any acts or omissions by CareFirst or any Participating Provider. CareFirst is not an agent or representative of the Group and is not liable for any act or omission of the Group.

8.10 Administration of the Contract. CareFirst may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Contract.

8.11 Rights under Federal Law. The Contract may be subject to federal law including the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") and/or the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Group is the "Plan Administrator" for the purposes of ERISA and/or COBRA. As the Plan Administrator, it is the Group's responsibility to provide the Member with certain information, including access to, and copies of, plan documents describing benefits and rights to coverage under the Group health plan. Such rights include the right to continue coverage upon the occurrence of certain "qualifying events." Under HIPAA, Certificates of Creditable Coverage will be provided by CareFirst. In any event, the Member should check with the Group to determine their rights under ERISA, COBRA, and/or HIPAA, as applicable.

8.12 Rules for Determining Dates and Times. The following rules will be used when determining dates and times under the Contract:

A. All dates and times of day will be based on Eastern Standard Time or Eastern Daylight Saving Time, as applicable.

B. When reference is made to coverage being effective on a particular date, this means 12:01 a.m. on that date.

C. When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.

D. "Days" mean calendar days, including weekends, holidays, etc, unless otherwise noted.

E. "Year" refers to calendar year, unless a different basis is specifically stated.

8.13 Notices to the Subscriber. Notices to Subscribers required under the Contract shall be in writing directed to the Subscriber's last known address. It is the Group's responsibility to notify CareFirst of a Subscriber address change. The notice will be effective on the date mailed, whether or not the Subscriber receives the notice or there is a delay in receiving the notice.

8.14 Contract Binding on Members. The Contract can be amended, modified or terminated in accordance with any provision of the Contract or by mutual agreement between CareFirst and the Group. This does not require the consent or concurrence of Members. By electing coverage under the Contract, or accepting benefits under the Contract, each Member agrees (and if the Member is legally incapable of contracting, the representative of such Member agrees) to all the terms, conditions and provisions of the Contract.

8.15 Provider and Services Information. Listings of current In-Network Providers will be made available to Member's at the time of enrollment. Updated listings are available upon request.

8.16 Events outside of CareFirst's Control. An event outside of the control of CareFirst refers to a natural disaster, epidemic, complete or partial destruction of facilities, disability of a significant part of CareFirst staff, war (whether declared or not), riot, civil insurrection or any

similar event over which CareFirst cannot exercise influence or control.

8.17 Certificate of Creditable Coverage. CareFirst will furnish a written certificate of creditable coverage via first-class mail.

A. Termination of CareFirst Coverage Prior to Termination of Coverage under the Group.

If a Member's coverage under this Group Contract ceases before the Member's coverage under the Group ceases, CareFirst will provide sufficient information to the Group (or to another party designated by the Group) to enable the Group (or other party), after termination of the Member's coverage under the Group, to provide a certificate that reflects the period of coverage under this Group Contract.

B. Members for Whom Certificate Must be Provided; Timing of Issuance

1. Issuance of Automatic Certificates

a. Qualified Beneficiaries Upon A Qualifying Event

In the case of a Member entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the Member would lose coverage in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. CareFirst will provide the certificate no later than the time a notice is required to be furnished for a qualifying event relating to notices required under COBRA.

b. Other Members When Coverage Ceases

In the case of a Member who is not a qualified beneficiary entitled to elect COBRA continuation coverage, CareFirst will provide the certificate at the time the Member ceases to be covered under this Group Contract. CareFirst will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of Premiums).

If a Member's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease on the earliest date that a claim in denied due to the operation of the lifetime limit.

c. Qualified Beneficiaries When COBRA Ceases

In the case of a Member who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the Member became entitled to elect COBRA continuation coverage), CareFirst will provide the certificate at the time the Member's coverage under the COBRA continuation coverage ceases. CareFirst will provide the certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of Premiums). CareFirst will provide the certificate regardless of whether the Member has previously received a certificate under paragraph B.1.a of this

section.

2. Any Individual Upon Request

CareFirst will provide a certificate in response to a request made by, or on behalf of, a Member at any time while the Member is covered under this Group Contract and up to 24 months after coverage ceases. CareFirst will provide the certificate by the earliest date that CareFirst, acting in a reasonable and prompt fashion, can provide the certificate. CareFirst will provide the certificate regardless of whether the Member has previously received a certificate under paragraph B.1.b., paragraph 2 or B. 1.b of this section.

3. If the Group retroactively terminates a Member beyond the period specified in the Group Contract, the Group agrees to indemnify and hold harmless CareFirst, its subsidiaries, officers, employees, agents and contractors from any and all claims, actions, damages, liabilities, and expenses whatsoever (including reasonable attorney fees) incurred or for which liability for the payment of has been determined, as a result of any act or omission on the part of the Group or its subsidiaries, officers, employees, agents and contractors in connection with or related to any failure to comply with any provisions of law, regulation or administrative directive, relating to or concerning the providing of timely and adequate Certificates of Coverage and as the same is more fully addressed and set forth under the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any future amendments thereto.

C. Combining Information For Families

A certificate may provide information with respect to both a Subscriber and Dependents if the information is identical for each Member. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each Member and separately states the information that is not identical.

ATTACHMENT A

DESCRIPTION OF COVERED SERVICES

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
An independent licensee of the Blue Cross and Blue Shield Association
840 First Street N.E.
Washington, DC 20065

This Attachment describes the services eligible for coverage. The Plan will provide the benefits described in Attachment B for covered expenses incurred while you are an eligible Member, including any extension of benefits for which you are eligible It is important to refer to Attachment B to determine the percentage of covered charges that we will pay, the charges for which you will be responsible and any specific limits on the number of services that will be covered. Attachment B also lists important information about deductibles, out-of-pocket maximums and other features that affect your coverage, including the annual deductible, specific benefit limitations and, if applicable, the lifetime maximum.

SECTION 1
GENERAL PROVISIONS

1.1 Benefits Under the Preferred Provider Plan. The Preferred Provider Plan offers two levels of benefits. You may select the benefit level at which coverage will be provided each time care is sought. Under the Preferred Provider Plan, you may receive benefits for a particular service under either the In-Network component or the Out-of-Network component. You may not receive duplicate benefits for the same services.

1.2 In-Network Benefits. When In-Network benefits apply, you are eligible for a higher level of benefits than the Out-of-Network benefits. In-Network benefits apply in the following instances:

a. **Services Rendered By a Preferred Provider**. When you use a Preferred Provider, benefits are based on the Allowed Benefit. The level of benefits is reflected in Attachment B of the Agreement. Preferred Providers will submit claims to us directly for covered services. The Preferred Provider will accept 100% of the Allowed Benefit as full payment for covered services.

b. **Services Rendered By an Exempt Provider**. When you use an Exempt Provider, as defined below, benefits are based on the appropriate Allowed Benefit for the service or supply provided. The level of benefits (i.e., coinsurance and/or copayment) for Exempt Provider services will be those shown under In-Network Benefits in Attachment B of the Agreement. You may be responsible for amounts in excess of the Allowed Benefit for these services.

Exempt Provider means any Health Care Facility or Health Care Practitioner which, as a class, is not represented in the providers who have agreed to participate as Preferred Providers. Exempt Provider also includes any Health Care Facility or Health Care Practitioner that is physically located outside the geographic area of the Preferred Provider network. A listing of Exempt Provider classes is available from us upon request.

c. **Other Circumstances**. In-Network benefits also apply in the following instances:

- If your Preferred Provider refers you to a provider who is not a Preferred Provider.
- If you receive covered Emergency Services, as defined in section 4.4, below from a provider who is not a Preferred Provider.
- If a Preferred Provider is not reasonably available.

In each of these instances, benefits will be based on the appropriate Allowed Benefit for the service or supply provided. The level of benefits (i.e., coinsurance and/or copayment) for these Providers' services will be those shown under In-Network Benefits in Attachment B of the Agreement. You may be responsible for amounts in excess of the Allowed Benefit.

1.3 Out-of-Network Benefits. Out-of-Network benefits apply when you obtain covered services from a Provider who is not a Preferred Provider in a circumstance not addressed in section 1.2.b or 1.2.c, above. When Out-of-Network benefits apply, you will receive reduced benefits for covered services. When you use a provider that is not a Preferred Provider or other provider described in sections 1.2.b, above, benefits are based on the Allowed Benefit. The level of Out-of-Network benefits is shown in Attachment B of the Agreement. You may be responsible for amounts in excess of the Allowed Benefit for these services.

1.4 Overview of Cost Sharing and Maximum Amounts. This section summarizes the cost sharing and maximum amounts of your benefits program. Detailed information about these features can be found in the Schedule of Benefits, including specific terms and amounts and any special exceptions.

Deductibles:	For most covered services, you do not begin to receive benefits until you meet your deductible for that "year". Your deductible will be calculated either on a calendar year or contract year basis, depending on your coverage. This is explained in your Schedule of Benefits (Attachment B). Your deductible is met when you receive services that are subject to the deductible and pay for these yourself. Under the Preferred Provider Plan, there may be a single deductible for In-Network and Out-of-Network services or separate deductibles that apply to each. This is explained in your Schedule of Benefits. The Schedule of Benefits also provides important information about your deductible or deductibles, including the deductible amount(s), how the deductibles apply to In-Network and Out-of-Network services and a listing of the services that are subject to the deductible(s).
Coinsurance:	Once your deductible is met (or for services without a deductible), benefits are based on a sharing of costs between you and us. For most services, these costs are shared based on the percentage of expenses that we pay and the percentage that you must pay. These percentages are referred to as the coinsurance.
Copayment:	A copayment is similar to coinsurance, except that copayments are set as a fixed dollar amount, rather than as a percentage of expenses.
Out-of-Pocket Maximums:	The out-of-pocket maximums limit the maximum amounts that you will have to pay for your share of benefits in any given year. Once you meet your out-of-pocket maximum, you will no longer be required to pay your share of the coinsurance for the remainder of that year. In addition, the out-of-pocket limits may apply to certain copayments and deductibles. Under the Preferred Provider Plan, there may be a single out-of-pocket maximum for In-Network and Out-of-Network services or separate out-of-pocket maximums that apply to each. This is explained in your Schedule of Benefits. The Schedule of Benefits also provides important information about your out-of-pocket maximum or maximums, including the maximum out-of-pocket amount(s), how the out-of-pocket maximums apply to In-Network and Out-of-network services and a listing of the expenses that are subject to the out-of-pocket maximum(s).
Lifetime Maximum:	If your coverage has a Lifetime Maximum (this will be shown on your Schedule of Benefits, Attachment B), there is a cap on the total benefits that we will pay on your behalf in your lifetime. If a Lifetime Maximum applies to your coverage and you reach the lifetime maximum, you will thereafter have either no benefit or only a limited "Annual Restoration Benefit. " Check your Schedule of Benefits.

1.5 Benefit Terms Defined. In addition to the previously defined terms, the Description of Covered Services uses certain defined terms. These terms are usually defined for you in the Section in which they first appear. The following terms are also used:

Allowed Benefit means:

For a Preferred Provider, the Allowed Benefit for a Covered Service will be the amount agreed upon between CareFirst and the Preferred Provider which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment and Coinsurance amounts, for which the Member is responsible.

For a Participating Provider, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency; or the amount CareFirst allows for the

service in effect on the date that the service is rendered. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment and Coinsurance amounts, for which the Member is responsible.

For a Non-Participating Practitioner, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit for a Participating Provider. The benefit is payable to the Member or to the provider, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts and for the difference between the Allowed Benefit and the Practitioner's actual charge.

For a Non-Participating Facility, the Allowed Benefit for a Covered Service is the Facility's actual charge, which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the Member or to the Facility, at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, and Coinsurance amounts.

Ancillary Services means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hoyer/stair lifts, ramps, shower/bath bench, items available without a prescription.

Cosmetic means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Eligible Provider means either a Health Care Facility or a Health Care Practitioner, as these terms are defined below, licensed or otherwise authorized by law to provide health care services.

Emergency Services means those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

1. Serious jeopardy to the mental or physical health of the individual; or

2. Danger of serious impairment of the individual's bodily functions; or

3. Serious dysfunction of any of the individual's bodily organs; or

4. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst determines.

Habilitative Services means the process of educating or training persons with a disadvantage or disability caused by a medical condition or injury to improve their ability to function in society, where such ability did not exist, or was severely limited, prior to the habilitative education or training.

Health Care Facility means a hospital, ambulatory surgical facility or center, inpatient rehabilitation facility, home health agency, skilled nursing facility, hospice facility, hospice program or partial

hospitalization program that is licensed or certified, or both, to operate within the jurisdiction in which it is located.

Health Care Practitioner means a physician, dentist (D.D.S. or D.M.D.) or other provider of health care whose services, by law, must be covered subject to the terms of this Agreement, such as: a chiropodist, chiropractor, doctor of podiatry, doctor of surgical chiropody, nurse anesthetist, nurse midwife, nurse practitioner, optician, optometrist, physical therapist, physiotherapist, audiologist, psychologist, social worker, licensed clinical professional counselor, licensed clinical marriage and family therapist, and licensed clinical alcohol and drug counselor.

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-The-Counter medications and solutions.

Participating Provider means an Eligible Provider that contracts with us to be paid directly for rendering covered services to eligible Members of this program.

Preferred Provider means a Preferred Facility or a Preferred Practitioner, as defined below.

- **Preferred Facility** means a Participating Provider that is a facility and which has a written agreement with us to render covered services to you in accordance with the terms and conditions of the Preferred Provider Plan. The fact that a facility is a Participating Provider does not guarantee that the facility is a Preferred Facility.

- **Preferred Practitioner** means a Participating Provider who is a licensed Health Care Practitioner and who has a written agreement with us to render covered services to you in accordance with the terms and conditions of the Preferred Provider Plan. The fact that a Health Care Practitioner is a Participating Provider does not guarantee that the Health Care Practitioner is a Preferred Practitioner.

A listing of Preferred Providers will be provided to you when you enroll and is also available from us upon request. The listing of Preferred Providers is subject to change. You may confirm the status of any provider prior to making arrangements to receive care by contacting us for up-to-date information.

Rehabilitative Services include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an Illness. The goal of Rehabilitative Services is to return the individual to his/her prior skill and functional level.

Skilled Nursing Care means Medically Necessary skilled care services performed in the home, by a licensed Registered Nurse (RN) or licensed Practical Nurse (LPN). Skilled Nursing Care services must be based on a Plan of Treatment submitted by a Health Care Provider. Skilled Nursing Care visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if visits were not provided, a Member would have to be admitted to a hospital or Skilled Nursing Facility). Services of a home health aide, medical social worker or registered dietician may also be provided but must be performed under the supervision of a licensed professional (RN or LPN) nurse.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care or Rehabilitative Services.

1.6 Limitation on Provider Coverage. Services are covered only if the provider is an Eligible Provider as defined above. The provider must be licensed in the jurisdiction in which the services are rendered. In addition, to be covered, the services must be within the lawful scope of the services for which that provider is licensed. Coverage does not include services rendered to you by any individual who:

- is not an Eligible Provider, as defined above;
- is your spouse, mother, father, daughter, son, brother or sister; or
- resides in your home.

1.7 BlueCard Program. Like all Blue Cross and Blue Shield Licensees, CareFirst participates in a program called "BlueCard." BlueCard provides Members with an extended network of Participating Providers for out-of-area care. BlueCard's cooperative efforts are expanded in BlueCard PPO, which provides Members with an extended network of Preferred Providers for out-of-area care. Members participating in BlueCard are responsible for ensuring out-of-area care is rendered by Participating and or Preferred Providers. Whenever Members access health care services outside the geographic area CareFirst serves, the claim for those services may be processed through BlueCard and presented to CareFirst for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Members receive covered health care services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), CareFirst will remain responsible to the Group for fulfilling CareFirst's contractual obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interaction with its participating providers.

The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim

The calculation of the Members liability on claims for covered health care services Incurred outside the geographic area CareFirst serves and processed through BlueCard will be based on the lower of the Health Care Provider's billed charges or the negotiated price CareFirst pays the Host Blue.

The calculation of the Group liability on claims for covered health care services Incurred outside the geographic area CareFirst serves and processed through BlueCard will be based on the negotiated price CareFirst pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Health Care Provider contracts. The negotiated price paid to a Host Blue by CareFirst on a claim for health care services processed through BlueCard may represent:

1. The actual price paid on the claim by the Host Blue to the Health Care Provider ("Actual Price"), or
2. An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's Health Care Providers or one or more particular Health Care Providers ("Estimated Price"), or
3. An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Health Care Providers or for a specified group of Health Care Providers ("Average Price"). An

Average Price may result in greater variation to the Member and the Group from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Member and the Group is a final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by the Group being held in a variance account by the Host Blue, pending settlement with its participating Health Care Providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the Group and are eventually exhausted by Health Care Provider settlements and through prospective adjustments to the negotiated prices.

Statutes in a small number of states may require a Host Blue either:

1. To use a basis for calculating the Members liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim, or

2. To add a surcharge.

When Members receive Covered Services in these states, the Members' and Groups' liability for Covered Services will be calculated using these states' statutory methods. However, when this payment methodology results in a conflict of statutes or regulations between two states, CareFirst will comply with the statutes of the jurisdiction in which the Group's Contract was issued.

Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from participating Health Care Providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Health Care Provider audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require either correction on a claim-by-claim basis or on a prospective basis through an allocated reduction on future claims where recoveries cannot be linked to specific claims.

CareFirst will arrange to share such recoveries proportionately with the Group and Members in accordance with the terms and conditions of the Group's Contract.

BlueCard Fees and Compensation

The Group understands and agrees:

1. To pay certain fees and compensation to CareFirst which CareFirst is obligated under BlueCard to pay to the Host Blue, to the Blue Cross and Blue Shield Association, or to BlueCard vendors, unless CareFirst's contractual obligations with the Group require those fees and compensation to be paid only by CareFirst and

2. That fees and compensation under BlueCard may be revised from time to time without the Group's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard.

Some of these fees and compensation are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Also, some of these claim-based fees, such as the access fee

and the administrative expense allowance fee may be passed on to the Group as an additional claim liability. Other fees include, but are not limited to, an 800 number fee and a fee for providing PPO Health Care Provider directories, if applicable. If the Group does not have a complete listing, or wants an updated listing, of these types of fees or the amount of these fees paid directly by the Group should contact its CareFirst representative.

Utilization Management Requirements and BlueCard

The Utilization Management Requirements of the Contract, if any, shall apply to BlueCard. The Member is responsible for:

1. Ensuring all Utilization Management Requirements are followed;

2. Any penalties for not complying with such requirements; and, or

3. Charges for out-of-area care CareFirst deems not Medically Necessary; and/or not covered under the Contract.

However, there may be instances where BlueCard claims are subject to the Host Blue's utilization management requirements and/or provider network rules, which may vary slightly from those stated in the Contract. Such variances may result from state laws that differ from those in the jurisdiction in which the Group's Contract was issued or from contracts the Host Blue holds with its vendors/providers.

While CareFirst strives to provide consistent benefits for all Members, another plan's utilization management requirements/vendors and provider network rules may sometimes affect a Member's benefits. Members accessing health care services outside the geographic area CareFirst serves should call 1-800-810-BLUE (2583) for that plan's utilization management requirements/provider network rules.

BlueCard Program Applicability

The BlueCard Program does not apply to Dental Care Benefits; Prescription Drug Benefits; Vision Care Benefits.

BlueCard PPO

As a Member of a CareFirst BlueCross BlueShield Preferred Provider product, when you receive treatment under the BlueCard Program described above, you may take advantage of the "Host" Plan's preferred provider network. If you see a preferred provider from the Host Plan, you will receive benefits at the "In-Network" level and will only be responsible for your Coinsurance, Copayment, and/or Deductible. If you choose not to see a preferred provider from the Host Plan, when one was available to you, benefits will be administered at the "Out-of-Network" level.

To receive "In-Network" benefits through BlueCard PPO Program, the Member should follow the steps outlined below:

a.
b. 1. Call the BlueCard PPO number, 1-800-810-BLUE (2583), to obtain names of preferred providers in that area. (This phone number is also printed on your identification card).
c.
d. 2. Present your identification card with the PPO Logo to the preferred provider.
e.
f. 3. The preferred provider will render the service and submit the claim to the Host Plan. The claim will then be processed through the BlueCard Program described above.

g.
h. 4. The Member is responsible for obtaining authorization for the following services:

- Hospital Services
- Home Health Care Services
- Chiropractic Services
- Skilled Nursing Facility Services
- Hospice Care Services
- Outpatient Private Duty Nursing
- Treatment of Infertility, limited to:
    - Artificial Insemination (AI);
    - Intrauterine Insemination (IUI);
    - Assisted Reproductive Technology, including:
        - In Vitro Fertilization (IVF);
        - Gamete Intrafallopian Transfer (GIFT);
        - Zygote Intrafallopian Transfer (ZIFT)

Failure to receive authorization and to comply with the Utilization Management Requirements will result in penalties. Please consult your Schedule of Benefits, for more information.

If you receive services from a provider under the following circumstances, you will receive benefits at the "in-network" level:

- Emergency Medical Services;
- Receive services from an Exempt Provider,
- A Preferred Provider refers you to a Non-Preferred Provider.
- Services received when a PPO Provider was not (reasonably) available.

SECTION 2
UTILIZATION MANAGEMENT REQUIREMENTS

Important
Failure to meet the requirements of the Utilization Management Program may result in a reduction or denial of your benefits even if the services are otherwise medically necessary.

2.1 Utilization Management. Benefits are subject to review and approval under utilization management requirements established by the Plan. Through utilization management, we review your care and evaluate requests for approval of coverage in order to assess the medical necessity for the services, review the appropriateness of the hospital or facility requested and determine the approved length of confinement or course of treatment in accordance with Plan-established criteria. In addition, utilization management may include additional aspects such as second surgical opinion and/or preadmission testing requirements, concurrent review, discharge planning and case management. Failure or refusal of the Member to comply with notice requirements and other utilization management authorization and approval procedures will result in the denial of or a significant reduction in your benefits. If coverage is reduced or excluded for failure to comply with utilization management requirements, the reduction or exclusion may be applied to all services related to the treatment, admission or portion of the admission for which utilization management requirements were not met. The terms that apply to your coverage for failure to comply with utilization management requirements are set forth in the Schedule of Benefits.

2.2 Preferred Provider Responsibility. Preferred Providers are responsible for providing utilization management notices and obtaining necessary utilization management approvals on your behalf for certain types of services and/or episodes of care. These are designated in your Schedule of Benefits. For these services, you will not be responsible for notification and approvals. However, you must advise the Preferred Provider that you are covered under the Preferred Provider Plan. In addition, you must comply with utilization management requirements and determinations. If you refuse to follow these requirements, your coverage will be reduced or excluded. **In all other instances, it is your responsibility to comply with the utilization management requirements described in section 2.3, below.**

2.3 Member Responsibility. **Except as provided in section 2.2 above,** you are responsible for all utilization management requirements. It is your responsibility to assure that hospitals, physicians and other providers associated with your care cooperate with utilization management requirements. This includes initial notification in a timely manner, responding to our inquiries and, if requested, allowing our representatives to review medical records on-site or in our offices. If we are unable to conduct utilization reviews, your benefits may be reduced or excluded from coverage.

2.4 Procedures. To initiate Utilization Management review, you may directly contact us or you may arrange to have notification given by a family member or by the physician, provider, or facility that is involved in your care. However, these individuals will be deemed to be acting on your behalf. If you and/or your representatives fail to contact us as required or provide inaccurate or incomplete information, benefits may be reduced or excluded.

Share the requirements of this Section with your family members and other responsible persons who could arrange for your care in accordance with this Section in case you are unable to do so yourself.

We will provide you with additional information regarding utilization management requirements and procedures, including telephone numbers and hours of operation, at the time of enrollment and, additionally, at any time upon your request.

2.5 Services Subject to Utilization Management. Except as provided in section 2.2, above, it is your responsibility to meet the following requirements:

a. **Hospital Inpatient Services**. All hospitalizations require precertification (except for maternity). You must contact us (or have your physician or the hospital contact us) at least five business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because it is not medically feasible to delay the admission for five business days due to your medical condition, we must receive notification of the admission as soon as possible but in any event within 48 hours following the beginning of the admission or by the end of the first business day after the beginning of the admission, whichever is earlier.

b. **Inpatient Mental Health and Substance Abuse Services**. You must contact us (or have your physician, hospital, or other provider facility contact us) at least five business days prior to an elective or scheduled admission. If the admission cannot be scheduled in advance because care is required immediately due to your condition, we must receive notification of the admission as soon as possible but in any event within 48 hours following the beginning of the admission or by the end of the first business day after the beginning of the admission, whichever is earlier.

c. **Outpatient Mental Health and Substance Abuse Services**. CareFirst or its designee will review and evaluate claims for Outpatient Mental Health and Substance Abuse services to assess the medical necessity and appropriateness of the services. CareFirst will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment.

d. **Other Services**. If you require any of the following services, you must contact us (or have your physician, hospital, or other provider facility contact us) at least five business days prior to the anticipated date upon which the elective admission or treatment will commence:

- Home Health Services
- Skilled Nursing Facility Services
- Chiropractic Services
- Hospice Care
- Outpatient Private Duty Nursing
- Treatment of Infertility, limited to:
  - Artificial Insemination (AI);
  - Intrauterine Insemination (IUI);
  - Assisted Reproductive Technology, including:
    - In Vitro Fertilization (IVF);
    - Gamete Intrafallopian Transfer (GIFT);
    - Zygote Intrafallopian Transfer (ZIFT)

We reserve the right to make changes to the categories of services that are subject to utilization management requirements or to the procedures Members and/or providers must follow. We will notify you of these changes at least 30 days in advance.

2.6 Concurrent Review and Discharge Planning. Following timely notification as described above, we will instruct you or your representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment.

2.7 Case Management. This is a feature of this health benefit plan for a Member with a chronic condition, a serious illness, or complex health care needs. CareFirst will initiate and perform Case Management services, as deemed appropriate by CareFirst, which may include the following:

a. Assessment of individual/family needs related to the understanding of health status and physician treatment plans, self-care and compliance capability, and continuum of care;

b. Education of individual/family regarding disease, treatment compliance and self-care techniques;

c. Help with organization of care, including arranging for needed services and supplies;

d. Assistance in arranging for a principal or Primary Care Physician to deliver and coordinate the Member's care, and/or consultation with physician specialists; and

e. Referral of Member to community resources.

2.8 Appealing a Utilization Management Decision. If you or your provider disagree with a utilization management decision, we will review the decision upon your request. A utilization management appeal will be reviewed and decided upon by our Medical Director or Associate Medical Director. If necessary, the Medical Director or Associate Medical Director will discuss your case with your physician. Any non-certification or penalty may be appealed. Please contact Customer Service for more information on how to appeal a Utilization Management Decision.

SECTION 3
PHYSICIAN AND PROVIDER SERVICES

3.1 Preventive Services. Benefits are available for the following preventive services:

a. Well child visits including but not limited to the following :

° All visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control;

° Visits for the collection of adequate samples for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age, the first of which to be collected before two weeks of age;

° All visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics;

° The following services at each of the visits described above:

* A physical examination;

* A developmental assessment;

* Parental anticipatory guidance;

° Laboratory tests considered necessary by the physician as indicated by the services provided as described above.

b. The following cancer screening services:

° Pap smears, at intervals appropriate to the Member's age and health status, as determined by the Plan;

° Mammography services, at intervals described in the Schedule of Benefits); and

° Prostate cancer services - benefits are available for a medically recognized diagnostic examination which shall include a Digital Rectal Exam and the Prostate-Specific Antigen (PSA) Test. This service will pay in accordance with other cancer screening services such as Pap smears and Mammography services, as described in the Schedule of Benefits, but will not be subject to the same limitations.

° Colorectal Cancer Screening. Benefits are available for colorectal cancer screening in accordance with the latest guidelines issued by the American Cancer Society.

c. **Chlamydia Screening Test** means any laboratory test that:

° Specifically detects for infection by one or more agents of chlamydia trachomatis; and

° Is approved for this purpose by the Federal Food and Drug Administration.

° Other preventive services, if any, as set forth in your Schedule of Benefits.

Multiple Risk Factors means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

Coverage will be provided for an annual routine Chlamydia Screening Test for women who are:
a. under the age of 20 years if they are sexually active; and
b. 20 years or older if they have Multiple Risk Factors.

Coverage will be provided for an annual routine Chlamydia Screening Test for men who have Multiple Risk Factors.

Annual routine Chlamydia Screening Tests will be subject to the same Copayment or Coinsurance or Deductible that similar services are subject to.

3.2 Diagnostic and Treatment Services. Benefits are available for diagnostic and treatment services by a physician or other Health Care Practitioner. Coverage includes the following services in a medical officeor as a hospital outpatient:

a. Office visits, including care and consultation by primary care physicians and specialists. Coverage does not include charges for telephone consultations, failure to keep a scheduled visit, or completion of any form;

b. Diagnostic procedures, laboratory tests and x-ray services, including:

° electrocardiogram, electroencephalogram; tonography;

° laboratory services, including: prostate-specific antigen (PSA) tests and digital rectal exams when used for the purpose of guiding patient management in monitoring the responseto prostate cancer treatment and/or when used for staging in determining the need for a bone scan in patients with prostate cancer;

° diagnostic x-ray services, diagnostic ultrasound services;

c. Treatment and therapeutic services in connection with a covered procedure, including:

° chemotherapy (benefits for high dose chemotherapy are limited to covered procedures as stated in section 3.12);

° electroshock therapy;

° radiation therapy;

° radioisotope services.

d. Allergy tests, injections, and sera.

e. Speech therapy, occupational therapy or physical therapy for conditions that we determine are subject to improvement. Coverage does not include nonmedical ancillary services such as vocational rehabilitation, employment counseling, educational therapy, or services for the purpose of Habilitation. Habilitation means the process of educating or training persons with a disadvantage or disability to improve their ability to function in society where such ability to function would not be present without Habilitation.

f. Medical foods and low protein modified food products for the therapeutic treatment, under the direction of a physician, of inherited metabolic diseases. A low protein modified food product means

a food product that is specially formulated to have less than 1 gram of protein per serving (excluding a natural food that is naturally low in protein).

g. Services in connection with covered Hospital Emergency Room care (see section 4.4).

h. Chiropractic care. Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.

3.3 Maternity and Related Services.

a. **Complications of Pregnancy**. The following benefits are covered for all Members, subject to the limitations set forth in the Schedule of Benefits:

- Obstetrical care for an ectopic pregnancy, miscarriage or complications of pregnancy.
- Emergency (non-scheduled) cesarean section if medically necessary due to a complication in delivery, including post-natal care and routine newborn care while the mother is hospitalized for covered maternity care, provided the mother is a Member and the delivery was covered as an emergency cesarean section. Coverage of routine newborn care is limited to routine newborn visits (not to exceed two visits) and male circumcision. To qualify for coverage of other services, the newborn must be a Member in his or her own right.
- D&C or full term pregnancy for any female Member (including a Dependent) who became pregnant as the result of rape or incest. If the Member is covered solely by Standard Maternity Benefits (without Extended Maternity and Related Coverage), coverage will be provided only if the incident is reported to police authorities.

b. **Standard Maternity Benefits**. The following benefits are covered for all Members, subject to the limitations set forth in the Schedule of Benefits:

- Postpartum visits for home care of the mother and newborn child following discharge from hospitalization for childbirth, as may be prescribed by the attending provider. Home visits will:
  - be covered without copayments, coinsurance amounts or deductibles required under the Certificate or Agreement;
  - be provided in accordance with generally accepted standards of nursing practice for home care of the mother and newborn child;
  - be provided by a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health; and
  - include any services required by the attending provider.

  When we are notified of a member's pregnancy, we will provide the member with information, prior to the scheduled delivery date, on postpartum home visits for the mother and child, including the names of providers that are available for postpartum home visits.
- Voluntary sterilization of adult Members and surgical reversal of voluntary sterilization procedures.

c. Extended Maternity and Related Coverage. Consult your Schedule of Benefits to determine if you have Extended Maternity Coverage. If so, it is extended to all female participants for the following benefits, subject to the limitations set forth in the Schedule of Benefits: Member has met the above requirements.

- Obstetrical care for a normal pregnancy, an ectopic pregnancy, miscarriage or complications of pregnancy is covered for all female Employee/Member(s), a spouse and dependent children for maternity coverage. When applicable, coverage includes cesarean section if medically indicated, or delivery, including prenatal care and postnatal care. Following childbirth, coverage will be provided for a minimum hospital stay of not less than 48 hours following an uncomplicated vaginal delivery, or 96 hours following an uncomplicated cesarean section.
- If the delivery occurs in the Hospital the length of stay begins at the time of the delivery. If the delivery occurs outside of the Hospital the length of stay begins upon admission to the Hospital. The Member and provider may agree to an early discharge. Prior authorization is not required.
- Routine newborn care is included while the mother is hospitalized for covered maternity care, provided the mother is a Member and eligible for maternity benefits. The mother may request that the newborn also remain in the hospital for up to 4 days. Coverage is limited to routine newborn visits (not to exceed two visits) male circumcision, and up to two (2) well baby post-partum visits. To qualify for coverage of other services, the newborn must be a Member in his or her own right.
- Elective abortions.
- Medically Necessary services for the normal newborn (an infant born at approximately 40 weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination.
- Medically Necessary inpatient/outpatient Health Care Provider services for a newborn with congenital or comorbid conditions.
- **Infertility Services.** Benefits are provided for infertility services including artificial insemination and in-vitro fertilization, when the Member is married or in a Domestic Partnership.

  Benefits are limited to:

  - Infertility counseling;
  - Testing;
  - Assisted reproductive technologies as described and limited below.

- **Artificial Insemination**. **Benefits are available when:**

  1. Benefits are available when:

     a. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of at least 1 year of unprotected vaginal intercourse following the reversal of an elective sterilization procedure in order for artificial insemination to be covered.

     b. The Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination; and

     c. The treatment is pre-authorized by CareFirst.

  2. Any charges associated with the collection of sperm will not be covered unless the male donor is also a Member.

3. The Member is responsible for the copayment as stated in the Schedule of Benefits.

- **In-vitro Fertilization (IVF)**

1. Benefits (including zygote and gamete intra-fallopian transfer) are provided for outpatient expense arising from IVF procedures approved by the federal Food and Drug Administration that are performed at medical facilities that conform to:

   a. The American College of Obstetricians and Gynecologists guidelines for IVF clinics; or,

   b. The American Society for Reproductive Medicine minimal standards for IVF programs.

2. Benefits are available when:

   a. The treatment is pre-authorized by CareFirst;

   b. The oocytes (eggs) are physically produced by the Member and fertilized with sperm;

   c. The Member has been unsuccessful through less costly infertility treatment for which coverage is available; and

   d. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration; or, the infertility is associated with any of the following medical conditions:

      i. Endometriosis;

      ii. Exposure in utero to diethylstilbestrol, commonly known as DES.

      iii. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); however, if blockage is due to an elective sterilization procedure, the Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must also have a history of infertility of at least 2 years' duration following the reversal of an elective sterilization procedure.

      iv. Abnormal male factors, including oligospermia, contributing to the infertility.

3. Benefits, are limited to:

   a. A lifetime maximum benefit of $100,000.

   b. Three attempts per live birth.

   The lifetime maximum and benefit limits in no way create a right to benefits after termination of the Member's coverage under the evidence of coverage.

4. The Member will be responsible for the coinsurance as stated in the Schedule of Benefits.

When the Member has had a reversal of an elective male or female surgical sterilization procedure then:

1. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration following the reversal of an elective sterilization procedure in order for IVF procedures to be covered.

2. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of at least 1 year of unprotected vaginal intercourse following the reversal of an elective sterilization procedure in order for artificial insemination to be covered.

- **Exclusions and Limitations:**

1. Any costs associated with freezing, storage, and thawing of the female Member's eggs and/or male Member's or donor sperm for future attempts.

2. IVF procedures and any related testing or service that includes the use of donor eggs.

3. Any charges associated with donor eggs.

4. Costs associated with the freezing and storage of fertilized eggs (embryos).

5. No infertility services (Artificial Insemination/Intrauterine Insemination or In-Vitro Fertilization) in which a surrogate is involved will be covered.

6. Infertility services when the infertility is a result of elective male or female surgical sterilization procedures are not covered. When the Member has had a reversal of an elective male or female surgical sterilization procedure then:

   a. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of infertility of at least 2 years' duration following the reversal of an elective sterilization procedure in order for IVF procedures to be covered.

   b. The Member and the Member's spouse or Domestic Partner or in the case of a same sex Domestic Partnership, the Member must have a history of at least 1 year of unprotected vaginal intercourse following the reversal of an elective sterilization procedure in order for artificial insemination to be covered.

7. All self-administered fertility drugs. Coverage will be provided for self-administered in-vitro fertilization drugs if the Group does not provide a Prescription Drug Benefits Plan.

3.4 Surgical Care (Inpatient and Outpatient). Benefits are available for the following surgical procedures performed by Health Care Practitioners on an outpatient basis or a covered inpatient hospital

admission for which benefits are being provided under Section 4, subject to applicable utilization management requirements, if any, set out in Section 2.

a. Pre- and post-operative services are included in the Allowed Benefit. There are no separate benefits except as specified in this contract.

b. If multiple surgical procedures are performed during the same operative session, CareFirst will review the procedures to determine the benefits provided:

1. if the procedures are performed through only one route of access and/or on the same body system, and the additional procedures are clinically integral to the primary procedure, CareFirst will provide benefits as stated in the contract based on the Allowed Benefit for the primary surgical procedure. All other incidental, integral to/included in, or mutually exclusive procedures are not eligible for benefits.

2. if the additional procedures are not clinically integral to the primary procedure, including, but not limited to those that are performed at different sites or through separate incisions, CareFirst will consider them to be eligible for benefits. CareFirst will provide benefits as stated in the contract based on the Allowed Benefit for the most clinically intense surgical procedure, and the Allowed Benefits for other procedures performed during the same operative session will be reduced in accordance with established CareFirst guidelines."

3.5 Inpatient Medical Care. The following Inpatient Medical Care benefits apply if you are an inpatient in a Hospital under Section 4 following certification by Utilization Management of the medical necessity of the service provided:

a. Health Care Practitioner visits during your Hospital stay, one per day. Benefits are available for more than one inpatient visit per day if warranted by the complexity of your condition. Also, benefits are not available for inpatient visits on any day on which benefits for your hospitalization have been denied.

b. Intensive care which requires a Health Care Practitioner's attendance;

c. Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of your condition.

d. Inpatient diagnostic and treatment services provided and billed by a physician or other Health Care Practitioner, including:

- Diagnostic procedures, laboratory tests and x-ray services, including:
  - electrocardiogram, electroencephalogram; tonography;
  - laboratory services;
  - diagnostic x-ray services, diagnostic ultrasound services;

- Treatment and therapeutic services in connection with a covered procedure, including:
  - chemotherapy (benefits for high dose chemotherapy are limited to covered procedures as stated in section 3.12);
  - electroshock therapy;
  - radiation therapy;
  - radioisotope services.
  - physical therapy and inhalation therapy

Health Care Practitioner services provided to a hospitalized Member, including physician visits, charges for intensive care or consultative services, will be covered only if we determine that the Health Care

Practitioner rendered services to the Member and that such services were medically required to diagnosis or treat the Member's condition.

3.6 Anesthesia Service. Benefits are available for the administration of general anesthesia in connection with a covered medical or surgical procedure. To be eligible for separate coverage, the anesthesia must be administered by a Health care Practitioner other than the operating surgeon or assistant at surgery. For example, a local anesthetic used while performing a medical or surgical procedure is not generally viewed as a separately covered charge.

3.7 Blood and Blood Products. Benefits for blood and blood products (including derivatives and components) which are not replaced by or on behalf of the Member.

3.8 Ambulance Services. Benefits are available for medically necessary ambulance services to or from the nearest appropriate Hospital (as defined in Section 4.1).

a. **To or From Hospital**. Except as provided in paragraph "b" below, coverage of ambulance services is limited to Medically Necessary ambulance services to or from the nearest appropriate Hospital, as defined in Section 4.1.

b. **Foreign Transportation**. If the Member requires professional medical care for an injury or illness while traveling outside the United States, CareFirst or its authorized agent will cover the reasonable and necessary costs to transport the Member to a location where more appropriate medical care is available. Coverage includes air or ground ambulance services as Medically Necessary, as defined in Section 10.1.

3.9 Treatment for Cleft Lip and Cleft Palate. Benefits will be provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological and speech/language treatment for cleft lip and cleft palate.

3.10 Dental Services.

a. Dental benefits will be provided to repair or replace sound natural teeth that have been damaged or lost due to injury if:

- The injury did not arise while or as a result of biting or chewing;
- The injury occurred while the Member was covered under this Agreement (or another agreement issued by the Plan); and
- Treatment is commenced within six (6) months of the injury or, if due to the nature of the injury, treatment could not begin within 6 months of the injury, treatment began within 6 months of the earliest date that it would be medically appropriate to begin such treatment.

Benefits are limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

b. Dental benefits, including orthodontic treatment, will be provided for treatment of cleft lip or cleft palate as described in Section 3.9, above

Except as listed above, all other dental care is excluded from coverage. Benefits for oral surgery are described in section 3.23, below.

3.11 Organ/Tissue Transplants. Benefits for organ and tissue transplants are limited to the following procedures:

a. Kidney; cornea; bone; skin (for grafting or for any other medically necessary purposes);

b. Heart; combined heart and lung; single lung; double lung; pancreas, when performed simultaneously with a kidney transplant; liver. Prior to commencing a course of treatment for these procedures, you must obtain our written approval for both the procedure and the facility where the transplant will be done. No benefits will be provided for the facility, the procedure, or any resulting complication if you did not receive our advance written approval.

c. Autologous bone marrow or stem cell transplants that are not Experimental or Investigational as determined by CareFirst; and

d. Allogeneic bone marrow or stem cell transplants that are not Experimental or Investigational as determined by CareFirst.

e. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant. The cost of these drugs will not be counted towards any prescription drug benefit maximum under any endorsements and/or riders attached to the evidence of coverage.

f. Donor services are covered to the extent that they are not covered under any other health insurance plan or by any other source such as research funds or medical service grants. Donor benefits are provided for services that are related to the surgery. Coverage is provided for evaluating and preparing an actual donor and related recovery services after the donor procedures, regardless of whether the transplant is attempted or completed. Donor registry charges are covered.

g. Cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of 18 years) to and from the site of the transplant if approved by CareFirst. This benefit is available only when the covered transplant is not performed in the Service Area.

All charges directly or indirectly relating to the transplantation of non-human organs are excluded. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the evidence of coverage.

3.12 High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant. Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not Experimental or Investigational as determined by CareFirst.

3.13 Clinical Trials. Benefits for Patient Cost to a Member in a Clinical Trial will be provided in accordance with the terms below. All services must be pre-authorized or pre-approved by CareFirst.

a. Terms.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes:

1. The National Cancer Institute Clinical Cooperative Group;

2. The National Cancer Institute Community Clinical Oncology Program;

3. The Aids Clinical Trials Group; and,

4. The Community Programs For Clinical Research In Aids.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary service that is incurred as a result of the treatment being provided under the Clinical Trial. Patient Cost does not include:

1. The cost of an Experimental-Investigative drug or device;

2. The cost of non-health care services that a Member may be required to receive under the Clinical Trial;

3. Costs associated with managing the research associated with the Clinical Trial; or

4. Costs that would not be covered under the evidence of coverage for non-Investigative treatments.

b. Patient Cost related to a Clinical Trial will be covered if the Member's participation in the Clinical Trial is the result of:

1. Treatment studies provided for a life-threatening condition; or

2. Prevention, early detection, and treatment studies on cancer.

c. Coverage for Patient Cost for treatment being provided will be evaluated on a case-by-case basis. Coverage for Patient Cost will be provided only if:

1. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of cancer; or

2. The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for treatment, prevention and early detection of any other life threatening condition;

3. The treatment is being provided in a Clinical Trial approved by:

- One of the National Institutes of Health, such as the National Cancer Institute (NCI); or
- An NIH Cooperative Group or an NIH Center; or
- The FDA in the form of an Experimental-Investigative new drug application; or
- The federal Department of Veterans Affairs; or,
- An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office Of Protection From Research Risks of the NIH;

4. The facility and personnel providing the treatment are capable of doing so by virtue of their:

- Experience;
- Training; and,
- Volume of patients treated to maintain expertise;

5. There is no clearly superior, non-Investigative treatment alternative; and,

6. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Investigative alternative.

d. Coverage is provided for Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Member's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

3.14 Osteoporosis Prevention and Treatment Services. Coverage is available for Bone Mass Measurement for the prevention, diagnosis and treatment of osteoporosis when a Health Care Provider for the Qualified Individual requests the Bone Mass Measurement.

a. **Bone Mass Measurement** means a radiologic or radioisotopic procedure or other scientifically proven technology performed on a Qualified Individual for the purpose of identifying bone mass or detecting bone loss.

b. Qualified Individual means:

- An estrogen-deficient individual at clinical risk for osteoporosis;
- An individual with specific symptom suggestive of spinal osteoporosis, including roentgenographic oseopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
- An individual receiving long-term glucocorticoid (steroid) therapy;
- An individual with primary hyperparathyroidism; or
- An individual being monitored to access the response to or efficiency of an approved osteoporosis drug therapy.

3.15 Diabetes Self-Management Training. Coverage will be provided for diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician, or other appropriately licensed health care provider, to be necessary for the treatment of diabetes (Types I and II) or elevated blood glucose levels induced by pregnancy.

If deemed necessary, the diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through a program supervised by an appropriately licensed, registered or certified health care provider whose scope of practice includes diabetes education or management.

3.16 General Anesthesia for Dental Care. Benefits for general anesthesia and associated Hospital or ambulatory facility charges in conjunction with dental care will be provided to a Member under the following circumstances:

a. If the Member is:

1. Seven years of age or younger, or developmentally disabled;

2. An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member; and

3. An individual for whom a superior result can be expected from dental care provided under general anesthesia.

b. Or, if the Member is:

- Seventeen years of age or younger;
- An extremely uncooperative, fearful, or uncommunicative individual;
- An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and

c. An individual for who lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

d. Benefits for general anesthesia and associated Hospital or ambulatory facility charges are restricted to dental care that is provided by:

- A fully accredited specialist in pediatric dentistry;
- A fully accredited specialist in oral and maxillofacial surgery; and
- A dentist who has been granted Hospital privileges.

e. This provision does not provide benefits for general anesthesia and associated Hospital or ambulatory facility charges for dental care rendered for temporal mandibular joint disorders.

f. This provision does not provide benefits for the dental care for which the general anesthesia is provided.

3.17 Coverage for Habilitative Services for Children. Occupational Therapy, Physical Therapy and Speech Therapy for the treatment of a Dependent child under the age of 19 years with a congenital or genetic birth defect that enhance the Dependent child's ability to function. This includes a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defects include, but are not limited to: autism or an autism spectrum disorder and cerebral palsy.

3.18 Morbid Obesity. Benefits are provided for the surgical treatment of Morbid Obesity. The procedures must be recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and consistent with guidelines approved by the National Institutes of Health.

Morbid Obesity means:

A body mass index that is greater than 40 kilograms per meter squared; or

Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

As used above, body mass index is the practical marker used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

3.19 Hearing Aid for Minor Children. Covered Services for a minor Dependent child:

a. One Hearing Aid, prescribed, fitted and dispensed by a licensed audiologist for each hearing-impaired ear;

2. Non-routine services related to the dispensing of a covered Hearing Aid, such as assessment, fitting, orientation, conformity and evaluation.

3.20 Reconstructive Surgery. Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, as determined by CareFirst and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention.

3.21 Reconstructive Breast Surgery. Coverage will be provided for all stages of Reconstructive Breast Surgery of the breast on which the Mastectomy was performed.

a. **Mastectomy** means the surgical removal of all or a part of a breast as a result of breast cancer.

b. **Reconstructive Breast Surgery** means surgery performed as a result of a Mastectomy to reestablish symmetry between two breasts. Reconstructive Breast Surgery includes augmentation mammoplasty, reduction mammoplasty and mastoplexy.

Coverage will be provided for surgery and reconstruction of the other breast to produce a symmetric appearance.

Coverage will be provided for breast prostheses and services resulting from physical complications at all stages of Mastectomy including Lymphedemas.

3.22 Oral Surgery. Benefits include:

a. Medically Necessary procedures, as determined by the Plan, to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and are performed on sound natural teeth and supporting structures, lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.

b. Medically Necessary procedures, as determined by the Plan, needed as a result of an accidental injury, when the Member requests oral surgical services or the need for oral surgical services is identified in the patient's medical records within 60 days of the accident. Benefits for such oral surgical services shall be provided up to three (3) years from the date of injury.

c. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness.

d. All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of the malocclusion are excluded.

3.23 Human Papillomavirus Screening Test.

a. Coverage is provided for a human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

b. Human Papillomavirus Screening Test means any laboratory test that specifically detects for infection by one or more agents of the human papillomavirus and is approved for this purpose by the FDA.

SECTION 4
HOSPITAL SERVICES

Hospital benefits apply when you receive covered services at a Hospital (defined below) either as an inpatient or as an outpatient. Generally, when you receive care at a Hospital, the services include both a professional component and an institutional component. For example, if you have surgery, the Hospital may charge you for the operating room and equipment while the surgeon, anesthesiologist and radiologist may charge separately for their services. Benefits for professional services of Health Care Practitioners are described in Section 3; the benefits described in this Section apply to the institutional services that are provided and billed by the Hospital.

4.1 Hospital Defined. The benefits of this Section apply only to institutions that are operated in accordance with the laws of the jurisdiction in which they are located pertaining to institutions identified as hospitals, and primarily engaged in providing, for compensation from their patients on an inpatient basis, diagnostic and therapeutic facilities for surgical and/or medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of duly licensed doctors of medicine, and which continuously provides twenty-four (24) hour a day nursing service by registered graduate nurses, and which is not, other than incidentally, a place for the aged, or a nursing or convalescent home or institution.

Ancillary Services means services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, durable medical equipment and medical supplies. Ancillary Services do not include room and board services billed by a Hospital for inpatient care.

4.2 Inpatient Hospital Services.

a. Semiprivate room (2 or more patients);

b. Private room and board accommodations only if:
- no semiprivate rooms are available at the time of admission (until one becomes available) or
- you must be isolated to prevent contagion; or
- the law requires your isolation due to a communicable disease or an infectious condition.

c. Operating, recovery, anesthesia, intensive care, coronary care and cystoscopic room;

d. Hospitalization for Maternity. Obstetrical care for a normal pregnancy, an ectopic pregnancy, miscarriage or complications of pregnancy is covered for all female Employee/Member(s). When applicable, coverage includes cesarean section if medically indicated, or delivery, including prenatal care and postnatal care. Following childbirth, coverage will be provided for a minimum hospital stay of not less than 48 hours following an uncomplicated vaginal delivery, or 96 hours following an uncomplicated cesarean section.

If the delivery occurs in the Hospital the length of stay begins at the time of the delivery. If the delivery occurs outside of the Hospital the length of stay begins upon admission to the Hospital. The Member and provider may agree to an early discharge. Prior authorization is not required.

Routine newborn care is included while the mother is hospitalized for covered maternity care, provided the mother is a Member and eligible for maternity benefits. The mother may request that the newborn also remain in the hospital for up to 4 days. Coverage is limited to routine newborn visits (not to exceed two visits) male circumcision, and up to two (2) well baby post-partum visits. To qualify for coverage of other services, the newborn must be a Member in his or her own right.

e. Anesthesia materials;

f. Meals, including special diets;

g. General nursing service (private duty nursing is excluded);

h. Drugs and medicines provided by the Hospital while you are a patient in the Hospital, including intravenous solutions and injections, provided that such drugs and medications are listed in "The United States Pharmacopeia Dispensing Information", "The American Hospital Formulary Service Drug Information" or "The American Medical Association Drug Evaluations" at the time they are administered to the Member;

i. Oxygen, including the use of equipment for its administration;

d. Blood handling; sera (including blood, blood plasma and blood expanders);

k. Inpatient diagnostic and treatment services provided and billed by the Hospital, including:

- Diagnostic procedures, laboratory tests and x-ray services, including:
  - electrocardiogram, electroencephalogram; tonography;
  - laboratory services;
  - diagnostic x-ray services, diagnostic ultrasound services;

- Treatment and therapeutic services in connection with a covered procedure, including:
  - chemotherapy (benefits for high dose chemotherapy are limited to covered procedures set forth in section 3.12);
  - electroshock therapy;
  - radiation therapy;
  - radioisotope services.
  - physical therapy and inhalation therapy

l. All other care in the nature of usual hospital services that are medically necessary for the care and treatment of the patient, provided that those services cannot be rendered in an outpatient setting and are not otherwise specifically excluded under your Agreement.

4.3 Outpatient Hospital Care. Benefits are available for the following outpatient services rendered in the outpatient department of a Hospital or in an ambulatory surgical facility, in connection with a covered medical or surgical procedure under Section 3:

a. Use of operating room and recovery room;

b. Use of special procedure rooms;

c. Hemodialysis;

d. Laboratory, x-ray and machine tests;

e. Chemotherapy and radiation therapy (benefits for high dose chemotherapy are limited to covered procedures as stated in section 3.12);

f. Cardiac rehabilitation if:

- The Member has been diagnosed as having angina pectoris or has been hospitalized for a diagnosed myocardial infarction or coronary surgery; and

- The program is approved in advance by the Plan as meeting the following requirements:

  - The program must be provided or coordinated by a Hospital or other facility that we have previously approved to provide these services;

  - The program must provide continuous cardiac rehabilitative exercise, education and counseling.

  A list of approved cardiac rehabilitation providers is available upon request.

4.4 Emergency Room Services. Benefits for services received in or through a Hospital emergency room are limited to Emergency Services, only, as defined below.

"Emergency Services" means those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in: (i) serious jeopardy to the mental or physical health of the individual; or (ii) danger of serious impairment of the individual's bodily functions; or (iii) serious dysfunction of any of the individual's bodily organs; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as we determine.

SECTION 5
HOME HEALTH CARE

5.1 Qualified Home Health Agency. The benefits described in section 5.2 are available only when the patient is under the care of a Qualified Home Health Agency, as defined below.

A **Qualified Home Health Agency** is a licensed program which is a Participating Provider or which is approved for participation as a home health agency under Medicare or certified as a home health agency by the Joint Commission on Accreditation of Healthcare Organizations or any successor.

5.2 Covered Home Health Care. The home health benefits listed below are available when care is received from a Qualified Home Health Agency, subject to our certification of the need and continued appropriateness of such services in accordance with our utilization management requirements.

a. Part-time or intermittent home nursing care by a licensed professional (LPN or RN) nurse.

b. Respiratory, speech, audiology, physical and occupational therapy that we determine will result in improvement of your condition and achieve demonstrable treatment objectives, as identified in the Qualified Home Health Agency's treatment plan.

c. Part-time or intermittent home health aide services.

d. Drugs and medications directly administered to the patient during a covered home health visit, including home intravenous infusion therapy and incidental medical supplies directly expended in the course of a covered home health visit. Drugs and medications for home use (other than as described above) are not covered, except as may be provided under a separate Rider or Endorsement issued in conjunction with this Agreement. Medical supplies and purchase or rental of durable medical equipment is covered under Section 9, below.

e. Covered diagnostic tests and laboratory services.

f. Services of a medical social worker.

g. Nutrition guidance by a registered dietician;

h. Ambulance services to or from a Hospital when your condition is such that other methods of transportation would be hazardous to your health.

5.3 Conditions for Coverage. Home Health Services must be authorized or approved by us under our utilization management requirements as meeting the following conditions for coverage:

a. The Member must be confined to "home" due to a medical condition. "Home" can not be an institution, convalescent home or any facility which is primarily engaged in rendering medical or rehabilitative services to sick, disabled or injured persons.

b. The home health visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if home health visits were not provided, the Member would have to be admitted to a Hospital or Skilled Nursing Facility).

c. The Member must require and continue to require skilled nursing care or rehabilitation services "Skilled nursing care" means non-custodial care that requires medical training as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for performance.

d. The need for home health services must not be custodial in nature (see section 5.4, below).

e. The plan of treatment covering the Home Health Care service is established and approved in writing by the attending physician.

f. All services must be arranged and billed by the Qualified Home Health Agency. Providers may not be retained directly by the Member.

5.4 Additional Benefits. Home health visits following mastectomy or surgical removal of a testicle.

For a Member who receives less than 48 hours of inpatient hospitalization following a mastectomy or the surgical removal of a testicle, or who undergoes a mastectomy or the surgical removal of a testicle on an outpatient basis, benefits will be provided for:

- One home visit scheduled to occur within twenty-four (24) hours after discharge from the Hospital or outpatient health care facility; and

- An additional home visit if prescribed by the Member's attending physician.

5.5 Custodial Care Is Not Covered. Benefits will not be covered under this Agreement (for Home health services or any other covered services) for any visits or services which we determine were provided primarily for custodial care. Custodial care is care which does not require the continuing attention of trained medical personnel. This includes any service which can be learned and provided by an average individual who does not have medical training. Examples of custodial care include:

a. Assistance in performing the activities of daily living, such as feeding, dressing, and personal hygiene;

b. Administration of oral medications, routine changing of dressing, or preparation of special diets; or

c. Assistance in walking or getting in or out of bed.

These services are custodial even if the Member cannot provide this care for himself or herself because of age or illness and even if there is no one in the Member's household who can perform these services for the Member.

SECTION 6
SKILLED NURSING FACILITY SERVICES

6.1 Covered Skilled Nursing Facility Services. The services listed below are covered only in a "Qualified Skilled Nursing Facility" as defined below during a Plan-approved confinement. Coverage for Skilled Nursing Facility Services is subject to our certification of the need for Skilled Nursing Facility confinement and the appropriate length of stay for such confinement in accordance with our utilization management requirements.

a. Room and board in a semiprivate room.

b. The following inpatient physician and medical services if we determine that the Health Care Practitioner rendered services to you and that such services were medically required to diagnose or treat your condition. In addition you must be eligible for Skilled Nursing Facility benefits **for the day on which these services are rendered to you:**

- Health Care Practitioner visits during your Hospital stay, one per day*;
- Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of your condition.

*Benefits are available for more than one inpatient visit per day if warranted by the complexity of your condition. Also, benefits are not available for inpatient visits on any day on which benefits for your hospitalization have been denied.

c. Services and supplies ordinarily furnished by the facility to inpatients for diagnosis or treatment, including:

- Use of special equipment in the facility.
- Drugs, medications, solutions, biological preparations, and medical supplies used while the Member is an inpatient in the facility.

6.2 Qualified Skilled Nursing Facility. A "Qualified Skilled Nursing Facility" is a licensed facility which is approved for participation as a Skilled Nursing Facility under Medicare or certified as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or any successor. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.

6.3 Conditions for Coverage. Skilled Nursing Facility care must be authorized or approved by us as meeting the following conditions for coverage:

a. The admission to the Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Member were not admitted to a Skilled Nursing Facility, he or she would have to be admitted to a hospital).

b. The Member must require skilled nursing care or skilled rehabilitation services which:

- Are required on a daily basis;
- Are not custodial (see section 5.5, above); and
- Can only be provided on an inpatient basis.

c. The admission and continued confinement must be certified by us as meeting the criteria for coverage.

SECTION 7
HOSPICE CARE

7.1 Covered Hospice Care Services. Benefits will be provided for the services listed below when provided by a Qualified Hospice Care Program, as defined below. Coverage for Hospice Care Services is subject to our certification of the need and continued appropriateness of such services in accordance with our utilization management requirements.

a. Intermittent nursing care by or under the direction of a registered nurse.

b. Medical social services for the terminally ill patient and his or her Immediate Family. "Immediate Family" means the spouse, parents, siblings, grandparents, and children of the terminally ill Member.

c. Counseling, including dietary counseling, for the terminally ill Member.

d. Non-custodial home health visits as described in Section 5.

e. Services, visits, medical/surgical equipment or supplies; including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member.

f. Ambulance services, when medically required.

g. Family Counseling will be provided to the Immediate Family and the Family Caregiver before the death of the terminally ill Member when authorized or approved by us. "Family Counseling" means counseling given to the Immediate Family or Family Caregiver of the terminally ill Member for the purpose of learning to care for the Member and to adjust to the death of the Member. "Family Caregiver" means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill Member.

h. Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Member for the 6-month period following the Member's death or 15 visits, whichever occurs first. "Bereavement Counseling" means counseling provided to the Immediate Family or Family Caregiver of the Member after the Member's death to help the Immediate Family or Family Caregiver cope with the death of the Member.

i. Respite Care will be limited to an annual benefit of 14 days. "Respite Care" means temporary care provided to the terminally ill Member to relieve the Family Caregiver from the daily care of the Member.

j. 30 days of inpatient care per Member.

7.2 Conditions for Coverage. Hospice Care Services must be certified by us, provided by a Qualified Hospice Care Program (as defined below) and meet the following conditions for coverage**:**

a. The Member must have a life expectancy of 6 months or less.

b. The Member's attending physician must submit a written Hospice Care Services plan of treatment to us.

c. The Member must meet the criteria of the Qualified Hospice Care Program.

d. The need and continued appropriateness of Hospice Care Services must be certified by us as meeting the criteria for coverage in accordance with our utilization management requirements.

7.3 A "Qualified Hospice Care Program" is a coordinated, interdisciplinary program provided by a Hospital, Qualified Home Health Agency or other Health Care Facility that is licensed or certified by the state in which it operates as a Hospice Program and is designed to meet the special physical, psychological, spiritual and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing and other health services through home or inpatient care during the illness and bereavement period.

7.4 Hospice Eligibility Period. A Hospice Eligibility Period begins on the first date hospice services are rendered and terminates 180 days later or on the death of the terminally ill Member, if sooner. If the patient requires an extension of the Eligibility period, you or your representative must notify us in advance to request an extension of benefits. We reserve the right to extend the eligibility period on an individual case basis if we determine that the patient's prognosis and continued need for services are consistent with a program of Hospice Care.

7.5 Hospice Benefits Not Provided. The following are not covered:

a. Services, visits, medical equipment or supplies not required to maintain the comfort and manage the pain of the terminally ill member.

b. Financial and legal counseling

c. Any services for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.

d. Reimbursement for volunteer services.

SECTION 8
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

8.1 Covered Mental Health and Substance Abuse Care Services. Benefits will be provided for the services listed below for diagnosis, care and treatment of Mental Illness, Emotional Disorder and Alcohol Abuse and Drug Abuse, as defined in section 8.2, below. Coverage is subject to the limits described in the Schedule of Benefits, including limits on numbers of visits and days covered and, if applicable, limitations on the total benefits available for these services. In addition, coverage is subject to our certification of the need and continued appropriateness of such services in accordance with our utilization management requirements, if any, set out in Section 2.

8.2 Mental Health Conditions and Substance Abuse

Mental Health Conditions. Benefits for services required in connection with the diagnosis, care or treatment of Mental Health Conditions, as defined below, will be provided solely under and subject to the terms and conditions described in this Section. For the purposes of determining the benefits, if any, available under your Agreement, Mental Health Conditions are broadly defined as including any mental disorder, mental illness, psychiatric illness, mental condition or psychiatric condition (whether organic or non-organic, whether of biological, nonbiological, chemical or nonchemical origin, and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC.)

Substance Abuse. Substance Abuse refers to any pattern of pathological use of alcohol or of a drug, that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when the alcohol or drug is withdrawn. Detoxification services for Substance Abuse are covered under Sections 3 and 4.

8.3 Outpatient Mental Health and Substance Abuse Services. The following services are covered, subject to the terms and conditions outlined below and in accordance with the limits described in the Schedule of Benefits:

a. Diagnosis and treatment for mental illness and emotional disorders at physician offices, at other outpatient medical offices and facilities and at Qualified Partial Hospitalization Programs.

b. Diagnosis and treatment for alcohol abuse and drug abuse as defined above, including detoxification and rehabilitative services as an outpatient in a covered alcohol or drug rehabilitation program or Qualified Partial Hospitalization Program.

c. Other covered medical and medical ancillary services will be covered for conditions related to mental illness, emotional disorders, alcohol abuse and drug abuse on the same basis as other covered medical conditions.

8.4 Medication Management Office Visits. Office visits for medication management in connection with mental illness, emotional disorders, alcohol abuse or drug abuse.

8.5 Partial Hospitalization. Benefits are available for partial hospitalization in a Qualified Partial Hospitalization Program as defined below, subject to the limits described in the Schedule of Benefits.

A Qualified Partial Hospitalization Program means a licensed or certified facility or program that provides medically directed intensive or intermediate short-term treatment for mental illness, emotional disorder, drug abuse or alcohol abuse for a period of less than 24 hours but more than 4 hours in a day.

8.6 Inpatient Services. Benefits are available for inpatient treatment of mental illness, emotional disorders, alcohol abuse or drug abuse. When you are an inpatient in a Hospital or other Plan-approved Health Care facility for treatment of a mental illness, emotional disorders, alcohol abuse or drug abuse will be covered as follows:

a. Hospital benefits will be provided, as described in Section 4, on the same basis as a medical (non-Mental Health or Substance Abuse) admission, up to the limits described in the Schedule of Benefits for benefits under this section.

b. The following Inpatient Health Care Practitioner benefits apply if you are an inpatient in a Hospital under Section 4 following certification by Utilization Management of the medical necessity of the service provided:

- Health Care Practitioner visits during your Hospital stay, one per day*;
- Intensive care which requires a Health Care Practitioner's attendance;
- Consultation by another Health Care Practitioner when additional skilled care is required because of the complexity of your condition.

*Benefits are available for more than one inpatient visit per day if warranted by the complexity of your condition.

Health Care Practitioner services provided to a hospitalized Member, including physician visits, charges for intensive care or consultative services will be covered only if we determine that the Health Care Practitioner rendered services to the Member and that such services were medically required to diagnose or treat the Member's condition.

Coverage for inpatient Mental Health and Substance Abuse Services is subject to our certification of the need and continued appropriateness of such services in accordance with our utilization management requirements.

b. Diagnosis and treatment for alcohol abuse or drug abuse, including inpatient detoxification and rehabilitative services in an acute care hospital or Qualified Treatment Facility, as defined below.

A **Qualified Treatment Facility** means a non-residential facility or distinct part of a facility which is licensed in the jurisdiction(s) in which it operates and accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) as a substance abuse and alcohol treatment facility and which operates a program for the treatment and rehabilitation of alcohol and drug abuse.

Members must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by the Plan.

8.7 Residential Crisis Services.

a **Definitions:**

Residential Crisis Services means intensive mental health and support services that are:

1. Provided to a child or an adult Member with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the Member's ability to function in the community.

2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;

3. Provided outside of the Member's residence on a short-term basis in a community-based residential setting; and,

4. Provided by entities that are licensed by the Department of Health and Mental hygiene to provide residential crisis services.

b. **Covered Benefits:**

Benefits are available for Medically Necessary Residential Crisis Services. Coverage is subject to CareFirst certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements.

SECTION 9
MEDICAL DEVICES AND SUPPLIES

9.1 Benefits Provided. Benefits will be provided for Covered Medical Devices and Medical Supplies (as defined below). To qualify for benefits, the Member must have coverage under this Agreement at the time that the supply, equipment, prosthetic or appliance is prescribed and received. When Durable Medical Equipment is rented, the Member must continue to be eligible to receive benefits for the duration of time for which the equipment is authorized. Covered Medical Supplies are eligible for benefits.

9.2 Definitions

a. **Covered Medical Device**. As used in this Agreement, a Covered Medical Device means the following, subject to other terms and conditions of coverage, including the limitations and exclusions set forth in paragraph 3, below.

Covered Durable Medical Equipment means equipment furnished by a supplier, Qualified Home Health Agency or Hospice Care Program which is primarily and customarily used to serve a medical purpose; can withstand repeated use; generally is not useful to a person in the absence of illness or injury; is appropriate for use in the home; and is necessary and reasonable for the care or treatment of the Member's illness or injury. All requirements of this definition must be met before an item can be considered Covered Durable Medical Equipment. Items such as hospital beds, wheelchairs, home dialysis equipment, respirators, commodes and suction machines are examples of Covered Durable Medical Equipment.

Covered Prosthetic Device means an externally worn device which replaces a body part or performs or assists the patient in performing a bodily function. Covered Prosthetic Devices do not include eyeglasses or contact lenses (except when used as a prosthetic lens replacement for aphakic patients, as described below), hearing aids or dental prosthetics. Artificial limbs and implanted prosthetic devices, such as pacemakers and hip or knee joints are examples of Covered Prosthetic Devices. If you are aphakic due to intraocular surgery or an accidental injury, we will cover one pair of eyeglasses or contact lenses used to replace the natural lens and subsequent changes required due to a change in your prescription.

Covered Corrective Appliance means an externally worn brace which supports, aligns or corrects deformities to or improves the function of a limb or other moving body part, including soft or rigid gas permeable contact lenses or sclera shells for use in the treatment of a condition other than correction of vision. Corrective braces, casts, slings, and crutches, are examples of Covered Corrective Appliances.

b. **Covered Medical Supply**. Benefits for Covered Medical Supplies are limited to the items listed below. To qualify for benefits, Covered Medical Supplies must be prescribed or ordered by a Health Care Practitioner for the Member's own use and must be determined by us to be medically necessary and appropriate:

- Diabetic diagnostic supplies used to test blood and urine for glucose and used by a patient at home, including testing supplies for special diabetic equipment;
- Disposable syringes necessary to self-administer insulin or other covered injectables
- Ostomy and catheter supplies;
- Dialysis supplies;

- Oxygen;

- Medical foods for inherited metabolic diseases and inborn deficiencies of amino acid metabolism;

- Dressings required in connection with a covered injury, surgical procedure or condition.

9.3 Exclusions and Limitations.

a. Benefits will not be provided for purchase, rental or repair of:

- Medical equipment/supplies of an expendable nature, except as specifically listed a s a Covered medical supply in paragraph a., above. Non-covered supplies include incontinence pads or ace bandages.

- Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

- Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member, i.e., exercycle or other physical fitness equipment, elevators, hoyer lifts, shower/bath bench.

- Eyeglasses or contact lenses (except as stated above), dental prostheses or appliances, or hearing aids (except as otherwise provided herein for minor children).

- Corrective shoes (unless required to be attached to a leg brace), shoe lifts or special shoe accessories.

b. Benefits will be limited to the lower of purchase or rental, taking into account the length of time you required or are reasonably expected to require the equipment, the durability of the equipment, etc.

c. The purchase price or rental cost must be the least expensive of its type adequate to meet the medical needs of the Member. If the Member selects a deluxe version of the appliance, device or equipment not determined by us to be medically necessary, we will pay an amount which does not exceed our payment for the basic device (minus the Member copayment) and the Member will be fully responsible for paying the remaining balance.

d. Benefits for the repair, maintenance or replacement of Covered Durable Medical Equipment are limited as follows:

- Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.

- Coverage of repairs costs is limited to adjustment required by normal wear or by a change in the Member's condition and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the appliance, prosthetic or equipment.

- Replacement coverage is limited to once every two years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family Member are not covered.

9.4 Responsibility of the Plan. We will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of equipment) arising out of or in connection with the rental, sale, use, maintenance or repair of prosthetic devices, corrective appliances or durable medical equipment, whether or not covered under this Agreement.

SECTION 10
EXCLUSIONS

10.1 Medical Necessity and Appropriateness. Benefits will not be provided for services, tests, procedures or supplies which we determine are not necessary for the prevention, diagnosis or treatment of the Member's illness, injury or condition. Although a service or supply is listed as covered, benefits will be provided only if it is medically necessary and appropriate in the Member's particular case. A service or supply is medically necessary and appropriate only if, in our judgment it is:

Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by an Eligible Provider. We may consult with professional medical consultants, peer review committees, or other appropriate sources for recommendations on whether the services, supplies, or accommodations a Member receives are Medically Necessary.

10.2 Accepted Medical Practice. Benefits will not be provided for any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, in our judgment, is experimental, investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment. A service or supply is deemed to be experimental or investigational if:

a. A preponderance of scientific data, such as controlled studies in peer-reviewed journals or literature has not demonstrated that its use results in an improved net health outcome for a specific diagnosis;

b. It is not in accordance with generally accepted standards of medical practice; or

c. It does not have federal or other required governmental agency approval at the time it is received.

10.3 Free Care. Payment will not be made for services which, if the Member were not covered under the Group Contract, would have been provided without charge, including any charge or any portion of a charge which, by law, the provider is not permitted to bill or collect from the patient directly.

10.4 Routine Care of Feet. Routine palliative, or Cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet.

10.5 Dental Care. Except as provided in Section 3.10, benefits will not be provided for any other type of dental care including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, orthodontia, false teeth or any other dental services or supplies, unless provided in a separate Rider or Endorsement to this Agreement.

10.6 Oral Surgery. Except as otherwise provided in Section 3.10, Dental Services, and Section 3.23, Oral Surgery, all other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for cosmetic purposes or for correction of malocclusion are excluded.

10.7 Cosmetic Services. Cosmetic Services (except for Mastectomy – Related Services and services for cleft lip or cleft palate or both).

10.8 Prescription Drugs. Benefits will not be provided for prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require

administration by or under the direction of a physician are not covered, except as may be provided in a separate rider or endorsement to this Agreement, even though they may be dispensed or administered in a physician or provider office or facility.

10.9 Organ Transplants. Organ transplant procedures, including complications resulting from any such procedure, services or supplies related to any such procedure such as, but not limited to, high dose chemotherapy, radiation therapy or any other form of therapy, or immunosuppressive drugs are not covered, except as provided in Sections 3.11 and 3.12.

10.10 Other Exclusions. Benefits will not be provided for the following:

a. Services or supplies received before the effective date of your coverage under this Agreement.

b. Treatment of sexual dysfunctions or inadequacies limited to surgical implants for impotence (medical therapy and psychiatric treatment are not covered).

c. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.

d. Weight reduction and the treatment of obesity, except in the instance of Morbid Obesity.

e. Speech therapy, occupational therapy or physical therapy, unless we determine that your condition is subject to improvement. Coverage does not include nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

f. Fees and charges relating to fitness programs, weight loss or weight control programs, physical, pulmonary conditioning programs or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education. Cardiac rehabilitation programs are covered as described in Section 4.3.f.

g. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.

h. Services to the extent they are covered by any governmental unit, except in Veteran's Administration or armed forces facilities for services received, such as for non-service connected disabilities, for which the recipient is liable.

i. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers' compensation law.

j. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no fault insurance.

k. Services that are beyond the scope of the license of the provider performing the service.

l. Except for covered ambulance services, travel, whether or not recommended by an Eligible Provider.

m. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.

n. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

o. Benefits will not be provided for contraceptive devices or drugs, except for Depo-Provera, Intra-Uterine Devices (I.U.D's) and Norplant administered to the Member in the course of covered outpatient or inpatient treatment, which are covered.

p. Partial removal of a nail without the removal of the matrix.

q. Assistive reproductive procedures, other than those described in Section 3.3.c.

r. Any claim, bill or other demand or request for payment for health care services determined to be furnished as a result of a referral prohibited by Section I-302 of the Maryland Health Occupations Article.

s. Services solely on court order or as a condition of parole or probation unless approved by the Plan.

t. Any illness or injury caused by war, declared or undeclared, including armed aggression.

u. Any service, supply or procedure which is not specifically listed in your Agreement as a covered benefit.

v. Non-medical, provider services, including, but not limited to:

1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.

2. Administrative fees charges by a Health Care Provider to a Member to retain the Health Care Provider's medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Contract are limited to Covered Services rendered to a Member by a Health Care Provider.

w. Educational therapies intended to improve academic performance.

x. Vocational rehabilitation and employment counseling.

y. Treatment of temporamandibular joint disorders unless otherwise stated.

z. Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.

aa. Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.

bb. Habilitative Services

1. Services delivered through early intervention and school services.

2. Habilitative Services for a Member 19 years and older.

ATTACHMENT B1
SCHEDULE OF BENEFITS

HIGH OPTION

<table>
<tr><th colspan="2">HIGH OPTION GENERAL PLAN BENEFIT FEATURES</th></tr>
<tr><td colspan="2">DEDUCTIBLES</td></tr>
<tr><td>IN-NETWORK DEDUCTIBLE</td><td>OUT-OF-NETWORK DEDUCTIBLE</td></tr>
<tr><td>The Individual Deductible is $ 0 per calendar year.

The Family Deductible is $ 0 per calendar year.

The following amounts apply to the In-Network Deductible:

• 100% of the Allowed Benefit for covered In-Network services that are subject to the In-Network Deductible, as stated in the benefit chart below.

• Any amounts that have been applied to the Out-of-Network Deductible will also count toward your In-Network Deductible.</td><td>The Individual Deductible is $250 per calendar year.

The Family Deductible is $500 per calendar year.

The following amounts apply to the Out-of-Network Deductible:

• 100% of the Allowed Benefit for covered Out-of-Network services that are subject to the Deductible, as stated in the benefit chart below.

• Any amounts that have been applied to the In-Network Deductible will also count toward your Out-of-Network Deductible.</td></tr>
<tr><td colspan="2">IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES

If you have Individual Coverage, you must meet the Individual Deductible.

If you have Individual + Adult/Individual + Child Coverage, each Member must satisfy their own Deductible by meeting the Individual Deductible.

If you have Family Coverage, you can satisfy your own Deductible by meeting the Individual Deductible. In addition, eligible expenses of all covered members can be combined to satisfy the Family Deductible. An Individual family member cannot contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible is met in this manner, this will satisfy the Deductible for all covered family members.

The following amounts may <u>not</u> be used to satisfy the In-Network or Out-of-Network Deductibles:

• Copayments.

• Amounts incurred for failure to comply with the Utilization Management Program requirements.

• The portion of any provider charge that is in excess of the Allowed Benefit.

The benefit chart below indicates whether a covered service is subject to a Deductible. If a Deductible applies, the chart will also state whether a Deductible applies to In-Network benefits, Out-of-Network benefits, or both.</td></tr>
</table>

Out-Of-Pocket Limits	
IN-NETWORK	OUT-OF-NETWORK
The Individual Out-of-Pocket Limit is $1,000 per calendar year. The Family Out-of-Pocket Limit is $2,000 per calendar year. These amounts apply to the In-Network Out-of-Pocket Limit: • Coinsurance for Covered In-Network Services. • Copayments for Covered In-Network Services. • The In-Network Deductible. • The Out-of-Network Deductible. When you have reached the In-Network Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that calendar year for In-Network services.	The Individual Out-of-Pocket Limit is $2,000 per calendar year. The Family Out-of-Pocket Limit is $4,000 per calendar year. These amounts apply to the Out-of-Network Out-of-Pocket Limit: • Coinsurance for Covered Out-of-Network Services. • Copayments for Covered Out-of-Network Services. • The Out-of-Network Deductible. • The In-Network Deductible. When you have reached the Out-of-Network Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that calendar year for Out-of-Network services.

IN-NETWORK AND OUT-OF-NETWORK

If you have Individual Coverage, you must meet the Individual Out-of-Pocket Limit.

If you have Individual + Adult/Individual + Child, each Member must satisfy their own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit.

If you have Family Coverage, you can satisfy your own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit. In addition, eligible expenses of all covered members can be combined to satisfy the Family Out-of-Pocket Limit. An individual family member cannot contribute more than the Individual Out-of-Pocket Limit toward meeting the Family Out-of-Pocket Limit. Once the Family Out-of-Pocket Limit is met in this manner, this will satisfy the Out-of-Pocket Limit for all covered family members.

The following amounts may not be used to meet the In-Network or Out-of-Network Out-of-Pocket Limits:

- Coinsurance or Copayments, if any, for services covered under a Rider or Endorsement, unless specifically provided in the Rider or Endorsement.
- Amounts incurred for failure to comply with the Utilization Management Program requirements.
- The portion of any provider charges which is in excess of the Allowed Benefit.

MAXIMUM COMBINED OUT-OF-POCKET LIMIT

If you are using a combination of In-Network and Out-of-Network services, this feature avoids having to meet two separate Out-of-Pocket Limits. Your total Out-of-Pocket expenses (In-Network and/or Out-of-Network combined) are limited to your Out-of-Network Out-of-Pocket Limit amount. You can meet the Maximum Combined Out-of-Pocket Limit through any combination of In-Network and/or Out-of-Network Out-of-Pocket Limit expenses. If you meet your Maximum Combined Out-of-Pocket Limit, this automatically satisfies your In-Network and Out-of-Network Out-of-Pocket Limits for that year.

LIFETIME MAXIMUM
There is a Lifetime Maximum of $2,000,000. 100% of all benefit payments made to or on behalf of a Member are applied to the Member's Lifetime Maximum. If you exceed the Lifetime Maximum, your benefits thereafter will be limited to a Restoration Allowance of $2,500 per calendar year. For the remainder of the calendar year in which you exceed your Lifetime Maximum, the $2,500 Restoration Allowance will be reduced by the total amount of benefits you received that year before meeting your Lifetime Maximum.
UTILIZATION MANAGEMENT NON-COMPLIANCE
Failure or refusal to comply with Utilization Management Requirements will result in: Benefits for health care facility services associated with your care or treatment will be reduced by 50%.

BENEFITS				
SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
PHYSICIAN AND PROVIDER SERVICES				
Preventive Services				
Child Wellness	Up to age 18	100% of the Allowed Benefit, minus a Member Copayment of $10 per visit (Including related lab tests and immunizations)	NO	80% of the Allowed Benefit (Including related lab tests and immunizations)
Adult Preventive Physical Examinations	Age 18 and over Limited to one exam per calendar year	100% of the Allowed Benefit, minus a Member Copayment of $10 per visit (Including related services)	YES	80% of the Allowed Benefit (Including related services)

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Preventive Services (continued)				
Screening Mammography	Age 35-39: One baseline mammogram of each breast. Age 40-49: One preventive mammogram of each breast every two calendar years or more frequently if recommended by a physician. Age 50 and above: One preventive mammogram of each breast per calendar year.	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Routine Pap Smears	None	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Prostate Cancer Services	NONE	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Osteoporosis Prevention and Treatment Services	NONE	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Diagnostic and Treatment Services				
Office Visits	None	100% of the Allowed Benefit, minus a Member Copayment of $10 per visit	YES	80% of the Allowed Benefit
Allergy Shots	None	100% of the Allowed Benefit, minus a Member Copayment of $5 per visit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Diagnostic and Treatment Services (continued)				
Maternity and Related Services				
Standard Benefits	None	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Treatment of Infertility	The following Treatments of Infertility must be authorized in advance under the utilization management program: - Artificial Insemination (AI) - Intrauterine Insemination (IUI) - In Vitro Fertilization (IVF) - Gamete Intrafallopian Transfer (Gift) Zygote Intrafallopian Transfer (ZIFT) Your Preferred Provider will handle In-Network untilization management requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Surgical Care	Benefits apply on an inpatient or outpatient basis.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Inpatient Medical Care	Covered only if hospitalization qualifies for coverage.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Anesthesia Service	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure.	100% of the Allowed Benefit	NO	Covered at the In-Network Level (does not require the use of a Preferred Provider)
Ambulance Service	None	100% of the Allowed Benefit	NO	Covered at the In-Network Level (does not require the use of a Preferred Provider)
Spinal Manipulation	Benefits for chiropractic/spinal manipulation services are limited to Members who are twelve (12) years of age or older	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
HOSPITAL SERVICES				
Inpatient Hospital Services	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Inpatient and Outpatient Hospital Services performed by Radiologist, Anesthesiologist, Pathologist and Surgical Assistants		100% of the Allowed Benefit	No	Covered at the In-Network level (for services provided by Non-Participating Providers
Outpatient Hospital Services				
Emergency Room Treatment	None	100% of the Allowed Benefit, minus a Member Copayment of $50 per visit	NO	Covered at the In-Network Level (does not require the use of a Preferred Provider)

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Cardiac Rehabilitation	Limited to 90 days per calendar year.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
HOME HEALTH CARE				
	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf. Limited to 40 visits (up to four hours per visit) per calendar year.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
SKILLED NURSING FACILITY SERVICES				
	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf. Limited to 60 days per calendar year.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
HOSPICE CARE SERVICES				
	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf. Respite Care is limited to 14 days per Benefit Period Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Member for the 6-month period following the Member's death or 15 visits, whichever occurs first.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Outpatient Services				
Medication Management Office Visits	None	100% of the Allowed Benefit, minus a Member Copayment of $10 per visit	YES	80% of the Allowed Benefit
Neuropsychological Testing		80% of the Allowed Benefit	YES	80% of the Allowed Benefit
Methadone Maintenance Treatment		100% of the Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount	NO	100% of the Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
MENTAL HEALTH AND SUBSTANCE ABUSE CARE (continued)				
Other Outpatient Services	None	Per calendar year: Visits 1-5: 100% of the Allowed Benefit Visits 6-30: 80% of the Allowed Benefit Visits in excess of 30: 50% of the Allowed Benefit	YES	Per calendar year: Visits 1-5: 80% of the Allowed Benefit Visits 6-30: 65% of the Allowed Benefit Visits in excess of 30: 50% the Allowed Benefit
Partial Hospitalization	None	100% of the Allowed Benefit, minus a Member Copayment of $10 per visit	YES	80% of the Allowed Benefit
Hospital Inpatient	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
MEDICAL DEVICES AND SUPPLIES	None	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Hair Prosthesis	Benefits are limited to one hair prosthesis per calendar year	Allowed Benefit is up to $350 for one hair prosthesis	NO	Allowed Benefit is up to $350 for one hair prosthesis

ATTACHMENT B2
SCHEDULE OF BENEFITS

STANDARD OPTION

STANDARD OPTION GENERAL PLAN BENEFIT FEATURES	
DEDUCTIBLES	
IN-NETWORK DEDUCTIBLE	OUT-OF-NETWORK DEDUCTIBLE
The Individual Deductible is $ 0 per calendar year. The Family Deductible is $ 0 per calendar year. The following amounts apply to the In-Network Deductible: • 100% of the Allowed Benefit for covered In-Network services that are subject to the In-Network Deductible, as indicated in the benefit chart below. • Any amounts that have been applied to the Out-of-Network Deductible will also count toward your In-Network Deductible.	The Individual Deductible is $250 per calendar year. The Family Deductible is $500 per calendar year. The following amounts apply to the Out-of-Network Deductible: • 100% of the Allowed Benefit for covered Out-of-Network services that are subject to the Deductible, as indicated in the benefit chart below. • Any amounts that have been applied to the In-Network Deductible will also count toward your Out-of-Network Deductible.
IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES If you have Individual Coverage, you must meet the Individual Deductible. If you have Individual + Adult/Individual + Child Coverage, each Member must satisfy their own Deductible by meeting the Individual Deductible. If you have Family Coverage, you can satisfy your own Deductible by meeting the Individual Deductible. In addition, eligible expenses of all covered members can be combined to satisfy the Family Deductible. An Individual family member cannot contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible is met in this manner, this will satisfy the Deductible for all covered family members. The following amounts may <u>not</u> be used to satisfy the In-Network or Out-of-Network Deductibles: • Copayments. • Amounts incurred for failure to comply with the Utilization Management Program requirements. • The portion of any provider charge that is in excess of the Allowed Benefit. The benefit chart below indicates whether a covered service is subject to a Deductible. If a Deductible applies, the chart will also indicate whether a Deductible applies to In-Network benefits, Out-of-Network benefits, or both.	

Out-Of-Pocket Limits	
IN-NETWORK	OUT-OF-NETWORK
The Individual Out-of-Pocket Limit is $1,000 per calendar year. The Family Out-of-Pocket Limit is $2,000 per calendar year. These amounts apply to the In-Network Out-of-Pocket Limit: • Coinsurance for Covered In-Network Services. • Copayments for Covered In-Network Services. • The In-Network Deductible. • The Out-of-Network Deductible. When you have reached the In-Network Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that calendar year for In-Network services.	The Individual Out-of-Pocket Limit is $2,000 per calendar year. The Family Out-of-Pocket Limit is $4,000 per calendar year. These amounts apply to the Out-of-Network Out-of-Pocket Limit: • Coinsurance for Covered Out-of-Network Services. • Copayments for Covered Out-of-Network Services. • The Out-of-Network Deductible. • The In-Network Deductible. When you have reached the Out-of-Network Out-of-Pocket Limit, no further Coinsurance or Deductibles will be required in that calendar year for Out-of-Network services.

IN-NETWORK AND OUT-OF-NETWORK

If you have Individual Coverage, you must meet the Individual Out-of-Pocket Limit.

If you have Individual + Adult/Individual + Child, each Member must satisfy their own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit.

If you have Family Coverage, you can satisfy your own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit. In addition, eligible expenses of all covered members can be combined to satisfy the Family Out-of-Pocket Limit. An individual family member cannot contribute more than the Individual Out-of-Pocket Limit toward meeting the Family Out-of-Pocket Limit. Once the Family Out-of-Pocket Limit is met in this manner, this will satisfy the Out-of-Pocket Limit for all covered family members.

The following amounts may <u>not</u> be used to meet the In-Network or Out-of-Network Out-of-Pocket Limits:

- Coinsurance or Copayments, if any, for services covered under a Rider or Endorsement, unless specifically provided in the Rider or Endorsement.
- Amounts incurred for failure to comply with the Utilization Management Program requirements.
- The portion of any provider charges which is in excess of the Allowed Benefit.

MAXIMUM COMBINED OUT-OF-POCKET LIMIT

If you are using a combination of In-Network and Out-of-Network services, this feature avoids having to meet two separate Out-of-Pocket Limits. Your total Out-of-Pocket expenses (In-Network and/or Out-of-Network combined) are limited to your Out-of-Network Out-of-Pocket Limit amount. You can meet the Maximum Combined Out-of-Pocket Limit through any combination of In-Network and/or Out-of-Network Out-of-Pocket Limit expenses. If you meet your Maximum Combined Out-of-Pocket Limit, this automatically satisfies your In-

Network and Out-of-Network Out-of-Pocket Limits for that year.

LIFETIME MAXIMUM

There is a Lifetime Maximum of $2,000,000.

100% of all benefit payments made to or on behalf of a Member are applied to the Member's Lifetime Maximum.

If you exceed the Lifetime Maximum, your benefits thereafter will be limited to a Restoration Allowance of $2,500 per calendar year. For the remainder of the calendar year in which you exceed your Lifetime Maximum, the $2,500 Restoration Allowance will be reduced by the total amount of benefits you received that year before meeting your Lifetime Maximum.

UTILIZATION MANAGEMENT NON-COMPLIANCE

Failure or refusal to comply with Utilization Management Requirements will result in:
Benefits for health care facility services associated with your care or treatment will be reduced by 50%.

BENEFITS				
SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
PHYSICIAN AND PROVIDER SERVICES				
Preventive Services				
Child Wellness	Up to age 18	100% of the Allowed Benefit, minus a Member Copayment of $15 per visit (Including related lab tests and immunizations) Specialist Copayment of $30 per visit	NO	80% of the Allowed Benefit (Including related lab tests and immunizations)
Adult Preventive Physical Examinations	Age 18 and over Limited to one exam per calendar year	100% of the Allowed Benefit, minus a Member Copayment of $15 per visit (Including related services) Specialist Copayment of $30 per visit	YES	80% of the Allowed Benefit (Including related services)

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Screening Mammography	Age 35-39: One baseline mammogram of each breast. Age 40-49: One preventive mammogram of each breast every two calendar years or more frequently if recommended by a physician. Age 50 and above: One preventive mammogram of each breast per calendar year.	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Routine Pap Smears	None	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Prostate Cancer Services	NONE	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Osteoporosis Prevention and Treatment Services	NONE	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Diagnostic and Treatment Services				
Office Visits	None	100% of the Allowed Benefit, minus a Member Copayment of $15 per visit Specialist Copayment of $30 per visit	YES	80% of the Allowed Benefit
Allergy Shots	None	100% of the Allowed Benefit, minus a Member Copayment of $5 per visit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Maternity and Related Services				
Standard Benefits	None	First visit 100% of the Allowed Benefit, minus a Member Copayment of $30 Additional visits 100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Treatment of Infertility	The following Treatments of Infertility must be authorized in advance under the utilization management program: - Artificial Insemination (AI) - Intrauterine Insemination (IUI) - In Vitro Fertilization (IVF) - Gamete Intrafallopian Transfer (Gift) Zygote Intrafallopian Transfer (ZIFT) Your Preferred Provider will handle In-Network untilization management requirements on your behalf	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Surgical Care	Benefits apply on an inpatient or outpatient basis.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Spinal Manipulation	Benefits for chiropractic/spinal manipulation services are limited to Members who are twelve (12) years of age or older	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Inpatient Medical Care	Covered only if hospitalization qualifies for coverage.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Anesthesia Service	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Ambulance Service	None	100% of the Allowed Benefit	NO	Covered at the In-Network Level (does not require the use of a Preferred Provider)
HOSPITAL SERVICES				
Inpatient Hospital Services	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf.	100% of the Allowed Benefit minus the $150 Member Copayment	YES	80% of the Allowed Benefit
Inpatient and Outpatient Hospital Services performed by Radiologist, Anesthesiologist, Pathologist and Surgical Assistants		100% of the Allowed Benefit	No	Covered at the In-Network level (for services provided by Non-Participating Providers
Outpatient Hospital Services				
Emergency Room Treatment	None	100% of the Allowed Benefit, minus a Member Copayment of $50 per visit	NO	Covered at the In-Network Level (does not require the use of a Preferred Provider)
Cardiac Rehabilitation	Limited to 90 days per calendar year.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
HOME HEALTH CARE				
	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf. Limited to 40 visits (up to four hours per visit) per calendar year.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
SKILLED NURSING FACILITY SERVICES				
	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf. Limited to 60 days per calendar year.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
HOSPICE CARE SERVICES				
	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf. Respite Care is limited to 14 days per Benefit Period Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Member for the 6-month period following the Member's death or 15 visits, whichever occurs first.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Outpatient Services				
Medication Management Office Visits	None	100% of the Allowed Benefit, minus a Member Copayment of $15 per visit	YES	80% of the Allowed Benefit
Other Outpatient Services	None	Per calendar year: Visits 1-5: 100% of the Allowed Benefit Visits 6-30: 80% of the Allowed Benefit Visits in excess of 30: 50% of the Allowed Benefit	YES	Per calendar year: Visits 1-5: 80% of the Allowed Benefit Visits 6-30: 65% of the Allowed Benefit Visits in excess of 30: 50% the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PLAN COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Partial Hospitalization	None	100% of the Allowed Benefit, minus a Member Copayment of $30 per visit	YES	80% of the Allowed Benefit
Hospital Inpatient	Must be authorized in advance under utilization management program. Your Preferred Provider will handle In-Network utilization management requirements on your behalf.	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Neuropsychological Testing		80% of the Allowed Benefit	YES	80% of the Allowed Benefit
Methadone Maintenance Treatment		100% of the Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount	NO	100% of the Allowed Benefit after $10 Copay or 50% of the Allowed Benefit whichever is the greatest amount
MEDICAL DEVICES AND SUPPLIES	None	100% of the Allowed Benefit	YES	80% of the Allowed Benefit
Hair Prosthesis	Benefits are limited to one hair prosthesis per calendar year	Allowed Benefit is up to $350 for one hair prosthesis	NO	Allowed Benefit is up to $350 for one hair prosthesis

Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
202-479-8000

A not-for-profit health service plan

An independent licensee of the BlueCross and BlueShield Association

PRECERTIFICATION ELIMINATION AMENDMENT

This amendment is effective January 1,2005 or on the effective date or renewal date of the Contract or Agreement ("evidence of coverage") to which this amendment is attached. Notwithstanding any provision to the contrary, the evidence of coverage is amended as follows:

Precertification requirements for the following services are amended as follows:

1. REHABILITATION SERVICES:

Precertification is not required for Physical Therapy, or Occupational Therapy, or Speech Therapy services or for any other service provided by the same provider on the same day as these services.

Precertification is not required for services rendered by physical therapists, or occupational therapists, or speech therapists.

2. CHIROPRACTIC SERVICES:

Precertification is not required for Chiropractic Services or for any other service provided by the same provider on the same day as these services.

Precertification is not required for services rendered by chiropractors.

This amendment is issued to attach to your evidence of coverage. This amendment does not change the terms and conditions of the evidence of coverage, unless specifically stated herein.

Group Hospitalization and Medical Services, Inc.

William L. Jews
President and Chief Executive Officer